

FILED AUG 21 1944 318

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 7140

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Johns Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Mary Shepack

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 14 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 1 hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Lawrence Shepack

13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Maria Saitta

15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Lawrence Shepack  
(b) Address 4650a Natural Bridge Ave.

17. (a) Burial (b) Date thereof 8/16/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Ave.

19. (a) AUG 16 1944 (b) J. F. Bruce  
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17  
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 9 10  
(d) Street No. 4650a Natural Bridge Ave. (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15  
year 1944 hour 3 minute A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

that I last saw h. er alive on Aug 15, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

that developed New Born

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

White at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M.D. or other) \_\_\_\_\_

Address 4143 1/2 Newstead Date signed \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed; fact should be so stated above.**