

FILED SEP 30 1944
318

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Barnes Hospital **0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 1/2 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME DONALD HEWITT SHAW

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male **0** 5. Color or race White **0**

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 December 21 1923
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

<u>20</u>	<u>8</u>	<u>29</u>	hr. min.
-----------	----------	-----------	----------

9. Birthplace Lee Center Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business _____

12. Name Russell Shaw

13. Birthplace Lee Center Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Bess Heutt

15. Birthplace Amboy Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant F. S. Schilling, Jr.

(b) Address Mattoon, Ill.

17. (a) Removal (b) Date thereof 9-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lee Center, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) SEP 21 1944 (b) J. J. Medrich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Coles **999**

(c) City or town Mattoon
(If outside city or town limits, write "RURAL") **N.P.V.**

(d) Street No. 2700 Western
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country ?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 20
year 1944 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept. 14
1944 to Sept. 20 1944
that I last saw him alive on Sept. 20 1944
and that death occurred on the date and hour stated above.

Immediate cause of death BRONCHIECTASIS,
LEFT LOWER LOBE

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy NONE OBTAINED

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? _____

23. Signature M. C. Abney (M. D. or other) **0**
Address Barnes Hospital Date signed 9-20-44
While at work? _____ (Specify type of place) (e) Means of injury _____

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

20
17
9

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.....

W. Wilkins

Licensed Embalmer No. *3575*

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.