

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(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:
St. Mary's Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 01
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 11
(d) Street No. 6301 Rosebury
(If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Julia R. Shearer

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife Albert L. Shearer 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 25, 1853
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
91 5 15 hr. _____ min.

9. Birthplace Dayton Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Russell Folkerth
13. Birthplace Dayton Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Ann Greene
15. Birthplace England
(City, town, or county) (State or foreign country)

16. (a) Informant Edith L. Mathews

(b) Address 6361 Rosebury

17. (a) Removal (b) Date thereof 10/12/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dayton, Ohio

18. (a) Signature of funeral director Edith P. Ambruster

(b) Address 4234 Manchester

19. (a) OCT 11 1944 (b) E. S. McLawrence M.D.
(Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10
year 1944 hour 11.30 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from Sept 24
1944 to Oct 10 1944
that I last saw her alive on Oct 10 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Disease

Due to arteriosclerosis
hypertension

Due to _____
Other conditions hypertension (mild)
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Daniel L. Ketter (M. D. or other) _____
Address 607 N. Paul Date signed 10-11-44

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 *Thomas Eymet*

Licensed Embalmer No. 1284

P. O. Address St Louis Mo

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.

Registration District No. 317 Primary Registration District No. 6076

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Julia B. Shearer
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 25 Year 1945 Hour 10 Minute 30 M.
 21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

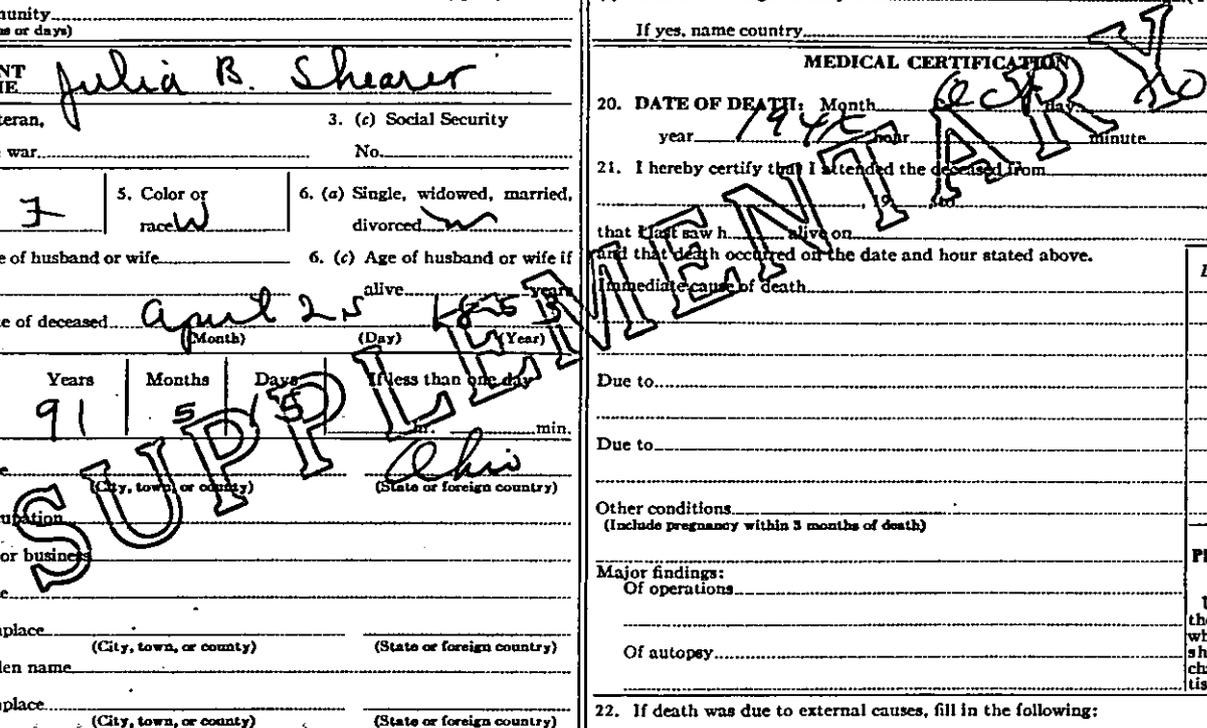
4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: April 25 1895
(Month) (Day) (Year)
 8. AGE: Years 91 Months 5 Days _____
(If less than one day _____ min.)

9. Birthplace Ohio
(City, town, or county) (State or foreign country)
 10. Usual occupation _____
 11. Industry or business _____
 12. Name _____
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
 17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) E. J. McLaughlin, M.D.
(Date received local registrar) (Registrar's signature) Address

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?
 While at work? _____
(Specify type of place)
 (e) Means of injury _____
 _____ (M. D. or other) _____
 _____ Date signed _____



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

MOTHER FATHER

35354