

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38782

State File No. _____

Registration District No. 317

Primary Registration District No. 2063

Registrar's No. 2310

1. PLACE OF DEATH

(a) County St. Louis County

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days)

In this community eight years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis

(c) City or town affler
(If outside city or town limits, write "RURAL")

(d) Street No. 6000 Staley
(If rural, give location)

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

3. (a) PRINT FULL NAME Susan Henshaw

3. (b) If veteran, name war XX

3. (c) Social Security No. XX

4. Sex 7 5. Color or race wh. 6. (a) Single, widowed, married, divorced 9

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

7. Birth date of deceased Sept 2 1868
(Month) (Day) (Year)

8. AGE: Years 76 Months 1 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Buchanan Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

12. Name Eso Shanks

13. Birthplace Mo
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Eweck

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

16. (a) Informant Mrs Ethel Rock

(b) Address 6000 Staley affler

17. (a) Burial (b) Date thereof 12-4-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lakewood Park Cem

18. (a) Signature of funeral director J. L. Ziegenhein & Sons

(b) Address 7027 Gravois Ave.

19. (a) NOV 13 1944 (b) E. H. McLawrence M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 10
year 1944 hour 6:40 minute A M.

21. I hereby certify that I attended the deceased from 11
7 1944 to 11-10 1944

that I last saw her alive on 11-10 1944

and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia Duration 2 days

Due to Chemical burn of left thigh = cellulitis 2 wks.

Due to _____

Other conditions Diabetes, genit ? direct
(Include pregnancy within 3 months of death)

Major findings: anticoagulant, embolism PHYSICIAN
Of operations _____

Of autopsy 1868
10-24-44 - date she fell

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

(a) Accident, suicide, or homicide (specify) _____ 096

(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 _____

Signature J. P. Wilson M.D. (M. D. or other)

Address St. Louis County Hosp Date signed 11-10-44

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

76
4
3

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: *C. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address. *7027 Travis*

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.