

Form No. 2
Rev. 5-17-39
I X36671

FILED MAR 23 1945

State File No. _____
Registrar's No. 2262

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County ST. LOUIS MO.
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
Name of hospital or institution:
Pronounced dead City Hospital
(If not in hospital or institution, write name and location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 6 yrs

3. (a) PRINT FULL NAME MORRISON SHAKLEFORD
3. (b) If veteran, name war WORLD WAR 3. (c) Social Security No. 2

4. Sex M 5. Color or race NEGRO 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: MAY 9 1918
(Month) (Day) (Year)

8. AGE: Years 26 Months 9 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace TUDELO MISSI
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business LUMBER YARD

12. Name JULIUS SHAKLEFORD

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

14. Maiden name ANNIE WOODS

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

16. (a) Informant ANNIE WOODS

(b) Address 1913 A DIVISION

17. (a) _____ (b) Date thereof 3-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NATIONAL CEM.

18. (a) Signature of funeral director Boyd Bros
(b) Address 3704 St. Finny Ave

19. (a) MAR 10 1945 (Date received local registrar) J. F. Bredbeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County _____
(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 1913 A DIVISION
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 6
year 1945 hour 3:10 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Internal Hemorrhage Duration _____
from laceration of Aorta; Fracture of Skull; when a cable supporting a boom broke causing same to fall and strike the deceased while working at the Wiles-Chipman Lumer Co. 234 So. Kingshighway Blvd. around 3:10 P.M. March 6, 1945.

Other conditions _____ (Include pregnancy within 3 months of death)
Charles Smith being the operator of the crane. PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence March 6, 1945
(c) Where did injury occur? St. Louis, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Industrial place

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

23. Signature [Signature] (M.D. or other) _____
Address _____ Date signed 3/10/45

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

MOTHER, FATHER

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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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No. 3704

P.O. Address No 3522

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.