

FILED SEP 29 1945

Registration District No. 319

Primary Registration District No. 3063

Registrar's No. 2275

1. PLACE OF DEATH:

(a) County St. Louis
 (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 of location)
 (d) Length of stay: In hospital or institution 5 days
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Allan Sharra

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

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Wid. 71
 6. (b) Name of husband or wife Bertha ? (dec) 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 1 - 15 - 1870
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 8 23 _____ hr. _____ min.

9. Birthplace Evansville Ind. 1
 (City, town, or county) (State or foreign country)

10. Usual occupation Caretaker

MOTHER FATHER

11. Industry or business
 12. Name Col. Sharra
 13. Birthplace Evansville, Ind. 1
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Thurecki Sister-in-law
 (b) Address 6447 Alamo
 17. (a) Removal (b) Date thereof 9/26/45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Evansville Indiana

18. (a) Signature of funeral director Robert J. Ambruster
 (b) Address 6633 Clayton Road
 19. (a) 9-23-45 (b) G. J. McFarland
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96
 (c) City or town Bemay 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. Sumaleyk Rd. Rivin Hollows 0
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24,
 year 1945 hour 10:25 minute A M.
 21. I hereby certify that I attended the deceased from
9-19- 1945, to 9-24- 1945;
 that I last saw him alive on 9-24- 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebrovascular Accident
Hypertensive Cardiovascular
Disease
 Due to aged.

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

Major findings: _____
 Of operations _____
 Of autopsy _____

Duration
 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?

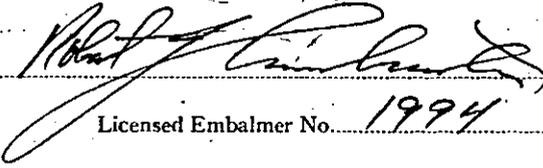
While at work? _____ (Specify type of place)
 Means of injury _____
 23. Signature Alan Hend (M. D. or other)
 Address 601 Brentwood Blvd Date signed 9-24-45

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

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.....


Licensed Embalmer No..... 1994

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.