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

31520

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 29 1945

State File No.

Registration District No. 2 F1

Primary Registration District No. 2002

Registrar's No. 2283

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
549 W. View Dr.
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96

(c) City or town University City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 549 W. View Dr. 5
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Helen Louise Shipley.

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Marion T. Shipley

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

7. Birth date of deceased July 31, 1865. (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80	1	24	hr. min.

9. Birthplace Springfield, Mo. (City, town, or county) (State or foreign country) 0

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Albert J. Signor
13. Birthplace New York (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Knott
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Julia Biggers
(b) Address 549 W. View Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26/45. (Month) (Day) (Year)
(c) Place: burial or cremation St. Patrick Cem., Alton, Ill.

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.

19. (a) 9-26-45 (Date received local registrar) (b) E. G. McGovran M.D. (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24
year 1945 hour 5.35 minute A.M. M.

21. I hereby certify that I attended the deceased from Jan 1904, 19__ to Sept 24, 1945
that I last saw her alive on Sept 23, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hardening of arteries	
Due to	
Due to 97	
Other conditions (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) no
(b) Date of occurrence Sept 25
(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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature J. D. Thurman (M. D. or other)
Address 6753 Page Date signed 9/24/45

707

(Licensed Embalmer's Statement on Reverse Side)

Dr. J.D.Thurmon
6753 Page Blvd.,
Pa. 3155.

1-3 PM

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 Alfred J. Boedeker

Licensed Embalmer No. 2663

P.O. Address 1125 Hodiamont Ave.

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.