V. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 25 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32366

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2959

1. PLACE OF DEATH:
(a) County
(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: De Paul Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days. (Specify whether years, months or days)
In this community

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. 4320a Natural Bridge.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MARY SHELLEY.
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F.
5. Color or race W.
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife James Shelley.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 10 (Day) 1865 (Year)

8. AGE: Years 80 Months 7 Days 5 If less than one day hr. min.

9. Birthplace St. Louis. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation At Home.
11. Industry or business

MOTHER FATHER
12. Name John Stafford.
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
14. Maiden name Teresa Dont Know.
15. Birthplace Dont Know. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Thomas F. Gallagher.
(b) Address 4320a Natural Bridge.
17. (a) Burial. (Burial, cremation, or removal) (b) Date thereof 10-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery.
18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd
19. (a) OCT 17 1945 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15th year 1945 hour 3 minute 05 P. M.
21. I hereby certify that I attended the deceased from Oct 5, 1945 to Oct 15, 1945 that I last saw her alive on Oct. 14, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Carcinoma Carcinomatosis of Liver

Due to

Due to

Other conditions Senility
(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) (e) Means of injury:

23. Signature Robert J. Farrell (M. D. ~~or other~~)
Address 624 N. Union Date signed 10/14/45

(Licensed Embalmer's Statement on Reverse Side)

Dr P Farrell
63 N Sem
1-3

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.