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I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35852

Registrar's No. 10316

Registration District No. 318 FILED DEC 7 1945 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis
(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 City Hosp #10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1535 Market St. (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME George Shettler
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Male
5. Color White
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Jan. 18 18 (Month) (Day) (Year)
8. AGE Years 67 Months ..... Days ..... If less than one day ..... hr. ..... min.
9. Birthplace Ill (City, town, or county) (State or foreign country)
10. Usual occupation Milk Inspector
11. Industry or business .....
FATHER 12. Name Wm Morris
FATHER 13. Birthplace ..... (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Mrs Morris
MOTHER 15. Birthplace ..... (City, town, or country) (State or foreign country)
16. (a) Informant Mrs. J. Coleman
(b) Address 300 Clay St.
17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis
18. (a) Signature of funeral director W. Ruth
(b) Address 3700 Ruth
19. (a) NOV 28 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7 year 1945 hour 2 minute 4 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 Chronic Endocarditis
Due to .....
Due to W.M.D.
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature Alfred Barry (M. D. or other)
Address ..... Date signed 11/19/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

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.