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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

**FILED** DEC 21 1945  
Registration District No. **318**

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. **1003**

State File No. **39787**  
Registrar's No. **10810**

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

1. PLACE OF DEATH:

(a) County St Louis, mo  
(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 Horn & Klutznick Hosp  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1418 Cleary St  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Eugene Shedrick  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. 428-361964

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 8 day 11  
year 1945 hour \_\_\_\_\_ minute 40 P.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race col  
6. (a) Single, widowed, married, divorced married  
(b) Name of husband or wife Fannie  
(c) Age of husband or wife if alive abt 42 years  
7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_  
Heart spreading outside chest, valve leakage, appendicitis & shock (surgical)

8. AGE: Years abt 44 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation Porter

11. Industry or business Brown shoe co

12. Name James Shedrick

13. Birthplace Col (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name Bethie Ann Post

15. Birthplace unknown (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Fannie Shedrick

(b) Address 1418 Cleary St

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

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director George W. Kaze

(b) Address 2829 Washington

19. (a) DEC 19 1945 (b) J. F. Bredeek  
(Date received local Registrar) (Registrar's signature)

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 Patrol E. Dwyer (M. D. or other)  
Date signed 12/10/45

**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. 4341

P. O. Address St. Louis 13, Mo.

**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.

4431 Garfield