

FILED JUN 30 1946
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community..... **15 yrs, 3 mos. 15 days**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **000**

(c) City or town..... **St. Louis, Mo.**
(If outside city or town limits, write "RURAL") **1317**

(d) Street No..... **5400 Arsenal St.**
(If rural, give location) **9**

(e) Citizen of foreign country?..... **Austria** (Yes or No) **0**
If yes, name country.....

3. (a) PRINT FULL NAME..... **GUSSIE SHAFFER**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **9**
year **1946** hour **6:45** minute..... P.M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced..... **Widow**

6. (b) Name of husband or wife..... **Joseph Shaffer** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... **Sept. 7 1888**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **6-8**, 19**46**, **6-9**, 19**46** that I last saw him or her alive on **June 9th**, 19**46** and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

57 **9** **?** hr. min. **4**

Immediate cause of death..... **Cerebral Hemorrhage** **2 days**

9. Birthplace..... **Austria**
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Housewife**

Due to.....

Due to.....

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

11. Industry or business.....

MOTHER FATHER { 12. Name..... **Unknown**

13. Birthplace..... **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name..... **Unknown**

15. Birthplace..... **Unknown**
(City, town, or county) (State or foreign country)

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN.....
Underline the cause to which death should be charged statistically.

16. (a) Informant..... **Mary Davenport**
(b) Address..... **5400 Arsenal**

17. (a) **Burial** (b) Date thereof..... **10/12/1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Chesed Shel Emeth Berger Memorial**

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?.....

18. (a) Signature of funeral director..... **Berger Memorial**
(b) Address..... **4715 McPherson Avenue**

19. (a) **JUN 21 1946** (b) **J. J. Bredek**
(Date received for local registration) (Registrar's signature)

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature..... **Jack R. DeLoach** (M. D. or other) **0**
Address..... **5400 Arsenal** Date signed..... **6/11/46**

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

Devro A. Jundurg
.....
Licensed Embalmer No. *4229*
.....
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.