

S. No. 2
 DM-5-43
 v. 5-17-39
 I X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **22203**
 Registrar's No. **5707**

FILED JUL 3 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 St. Louis, Mo.
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution St. Louis City Hospital
Max C. Starkloff Memorial
(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)

3. (a) PRINT FULL NAME CHARLES SHIROPSHIRE
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 11 1889
(Month) (Day) (Year)

8. AGE: Years 57 Months 0 Days 14
 If less than one day _____ hr. _____ min.

9. Birthplace Knoxville, Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation clerk

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)

16. (a) Informant John P. Cullinane

(b) Address Civil Courts Bldg.

17. (a) Burial (b) Date thereof 6-28-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Cullinane Bros.

(b) Address 3320 N. Kingshighway Blvd.

19. (a) JUN 28 1946 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 506 Chestnut St.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25
 year 1946 hour 9:00 minute A M.
 21. I hereby certify that I attended the deceased from June 4
 _____ 19 46 to June 25 19 46
 that I last saw h. in alive on June 25 19 46
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocardial Infarction
 Due to Arteriosclerotic Cardis -
Vascular disease

Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy Examined

Duration above
 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 Hubert Sweet (M. D. or other) _____
 Address 1515 Lafayette Ave. Date signed 6/25/46

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.....

Fred Frick

Licensed Embalmer No..... **3186**.....

P. O. Address..... **St. Louis, 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.