

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5148 Maple Ave.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME John Carroll McShane
 3. (b) If veteran, name war No
 3. (c) Social Security No. 495-16-3899

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 July 5, 1905
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 7 26 hr. _____ min.

9. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Insurance Adjuster

11. Industry or business Laclede Insurance Agency

MOTHER FATHER { 12. Name Jos. M. McShane
 13. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Nonie Carroll
 15. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nonie McShane
 (b) Address 5148 Maple Ave.

17. (a) Burial (b) Date thereof 3 - 4 - 47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Alvin S. Stewart
 (b) Address 1225 Union Blvd

19. (a) MAR 3 1947 (b) Registrar's signature J. J. Bidder
 (Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5148 Maple Ave.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1st
 year 1947 hour 8: minute 40 AM.

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.

Immediate cause of death _____
Cerebral Thrombosis
 Due to _____
94A
 Due to _____

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

Major findings: _____
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (c) 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 Alvin S. Stewart (M. D. or other) _____
 Address _____ Date signed 3/3/47

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

FILED

2-45
7-39
X47070

MAR 11 1947

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.....

Henry M. Bramme
.....
Licensed Embalmer No. 4200

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.