

No. 2  
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5-17-39  
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FILED APR 21 1947  
318

State File No. \_\_\_\_\_  
Registrar's No. 72774

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County MISSOURI

(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
EN ROUTE CITY HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Month) \_\_\_\_\_ (Year)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County \_\_\_\_\_

(c) City or town ST. LOUIS 1917  
(If outside city or town limits, write "RURAL")

(d) Street No. 4345 WASHINGTON  
(If rural, give location) U

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FRANK R. SHERMAN

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife BIRDIE 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DEC. 24 1886  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 8 year 1947 hour 9 minute 58A. 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 \_\_\_\_\_

8. AGE:

Years	Months	Days	If less than one day	
<u>60</u>	<u>3</u>	<u>15</u>	hr. _____	min. _____

Duration \_\_\_\_\_

Due to Coronary Sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace ST. LOUIS (City, town, or county) (State or foreign country) U

10. Usual occupation CHAUFFEUR

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name WILLIAM SHERMAN

13. Birthplace Mo. (City, town, or county) (State or foreign country) U

14. Maiden name FLORA HALLIDAY

15. Birthplace Mo. (City, town, or county) (State or foreign country) U

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? \_\_\_\_\_

16. (a) Informant FERN SHERMAN

(b) Address 3246 OHIO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 11 1947 (Month) (Day) (Year)

(c) Place: burial or cremation BETHANY CEM.

18. (a) Signature of funeral director Thomas Kuti 1 Son

(b) Address 2906 GRAYVOIS

19. (a) APR 9 1947 (Date received local registration) (b) J. F. Brudwick (Registrar's signature)

23. Signature Robert E. Taylor (Specify type of place) (c) Means of injury 3  
(M.D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 4/11/47

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

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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.....

*Samuel C. Hill*

Licensed Embalmer No.....

*4347*

P. O. Address.....

*2906 Travis*

**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.**