No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 12 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22648

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 6425

1. PLACE OF DEATH:

(a) County

(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 DePaul Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Day (Specify whether years, months or days)

In this community 3 Day

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 96

(c) City or town Riverview Gardens 0
(If outside city or town limits, write "RURAL")

(d) Street No. 9818 Jefferson Dr. 5
(If rural, give location)

(e) Citizen of foreign country? N.R. (Yes or No) /

If yes, name country

3. (a) PRINT FULL NAME ~~Baby~~ Infant Shellhart

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife — — — —

6. (c) Age of husband or wife if alive — — years

7. Birth date of deceased July (Month) 2 (Day) 1947 (Year)

8. AGE: Years | Months | Days 3 | If less than one day ~~4~~ hr. min.

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

10. Usual occupation Child

11. Industry or business

MOTHER FATHER

12. Name James Shellhart /

13. Birthplace Des Moines Iowa (City, town, or county) (State or foreign country)

14. Maiden name Jereline Sandefer /

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

16. (a) Informant Joe Sandefer

(b) Address 3504 Kossuth Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Friedrich F. Hamm

(b) Address 8319 Halls Ferry Rd.

19. (a) JUL 7 (Date received local registrar) (b) J. F. Brecheen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1947 hour 8 minute 55 P.M.

21. I hereby certify that I attended the deceased from 7/3/47, 19..., to 7/6/47, 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Atelectasis of Lung	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations

Of autopsy Atelectasis of Lung

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Paul Bernstaff (M. D. or other)

Address 3919 W. Florissant Date signed 7/7/47

PAUL BERNSTAFF

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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.....Arthur P. Diedrich.....

Licensed Embalmer No.....3556.....

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.