

318

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
5359 Reber Place  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Life years, months or days)

3. (a) PRINT FULL NAME Betty Tucker Shackelford

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

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife James A. Shackelford 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased: November 20, 1876  
(Month) (Day) (Year)

8. AGE: Years 71 Months 3 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Truxton Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name William A. Allen

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

14. Maiden name Mary Bostick

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

16. (a) Informant James A. Shackelford

(b) Address Ferguson, Missouri

17. (a) Burial (b) Date thereof March 2, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cemetery

18. (a) Signature of funeral director White Funeral Home

(b) Address Ferguson, Mo.

19. (a) MAR 2 1948 (b) J. F. Bradley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Ferguson  
(If outside city or town limits, write "RURAL")

(d) Street No. 303 Harrison Ave.  
(If rural, give location)

(e) Citizen of foreign country? --- (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 28  
year 1948 hour 2 minute 50 P.M.

21. I hereby certify that I attended the deceased from Jan  
1948, to Feb 1948  
that I last saw her alive on Feb. 28  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to myocardial failure  
Cardio-vascular disease

Due to 9/2

Other conditions Pernicious Anemia  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

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)

(c) Means of injury \_\_\_\_\_

23. Signature W. M. Keller M.D. (M. D. or other) \_\_\_\_\_

Address 32841 ... Date signed 3-2-48

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

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

St. Louis Mo.

*Handwritten mark*

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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 *L. M. Shluta*

Licensed Embalmer No. *3973*

P. O. Address *Ferguson, 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.**