

FILED NOV 12 1948

918

Primary Registration District No.

1003

.....

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

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **36 days**
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County.....
 (c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL")
City Infirmary
(If rural, give location)
 (d) Street No. **13**
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3: (a) PRINT FULL NAME **Charles Shobe**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **29**
 year **1948** hour **4** minute **15** a. **M.**

4. Sex **male** race **col.**

5. Color or race.....

6. (a) Single, widowed, married, divorced, separated.....
 6. (b) Name of husband or wife..... **Zellie Mae**
 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Sept. 23, 19**48**, to **Oct. 29**, 19**48**
 that I last saw him alive on **Oct. 29**, 19**48**
 and that death occurred on the date and hour stated above.

8. AGE: Years **37** Months **7** Days **28**
 If less than one day hr. min.

Immediate cause of death.....
Multiple Sclerosis

Due to.....
 Due to.....

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

Other conditions..... **Gastrointestinal Hemorrhage**
(Include pregnancy within 3 months of death)
and Atypical Pneumonia

11. Industry or business..... **Comptroller**

12. Name..... **Charles Shobe Sr.**

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

14. Maiden name..... **Minnie Walker**

15. Birthplace..... **Greenfield** (City, town, or county) **Ill.** (State or foreign country)

Major findings:
 Of operations.....
 Of autopsy..... **None**

16. (a) Informant..... **Mrs. Minnie Shobe**
(b) Address..... **3444 A Saddle ant**

17. (a) Burial..... (b) Date thereof: **11-4-48**
(Month) (Day) (Year)

(c) Place: burial or cremation..... **Washington Park**

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.....

18. (a) Signature of funeral director.....
(b) Address..... **4467 Washington St.**

19. (a) NOV 3 1948 (Date received local registrar) **J. B. [Signature]** (Registrar's signature)

23. Signature..... **Herbert [Signature]** (M. D. or other)
Address..... **2601 N Whittier**
Date signed..... **10/29/48**

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 Frederick P. Starks

Licensed Embalmer No. 4599

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.