

THE DIVISION OF HEALTH OF MISSOURI
 FILED MAY 27 1950 STANDARD CERTIFICATE OF DEATH

State File No. 18657
 4371
 Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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|-------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2069 | |
| c. LENGTH OF STAY (In this place) | | d. STREET ADDRESS (If rural, give location) 5806a Easton Ave | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 5806a Easton Ave | | | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Bently c. (Last) Shriver | | | 4. DATE OF DEATH (Month) (Day) (Year) May 15 1950 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2 | 8. DATE OF BIRTH Oct 3 1857 | 9. AGE (In years - last birthday) 92 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. |

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| 13a. FATHER'S NAME May E. Sutherland | 13b. MOTHER'S MAIDEN NAME Samuel K Bently | 14. NAME OF HUSBAND OR WIFE John Shriver Dec |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT'S SIGNATURE OR NAME: Ethel S. Gott | ADDRESS 5806a Easton Ave |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arterosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH one year ten years |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterosclerosis, gen'l. | | |
| | DUE TO (c) | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 4200 |

22. I hereby certify that I attended the deceased from 29 April, 1950, to 15 May, 1950, that I last saw the deceased alive on 7 May, 1950, and that death occurred at 12:35 P.M. from the causes and on the date stated above.

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| 23a. SIGNATURE Joseph W. Clark, M.D. | 23b. ADDRESS 5750 Washington, St. Louis | 23c. DATE SIGNED 16 May 1950 |
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|---------------------------------------|-------------------------|-------------------------------------------------------|------------------------------------------------------------|
| 24a. BURIAL CREMATION REMOVAL Removal | 24b. DATE 4 May 16 1950 | 24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery | 24d. LOCATION (City, town, or county) (State) Newton Kans. |
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| DATE REC'D BY LOCAL REG. 16 1950 | REGISTRAR'S SIGNATURE J. B. Suster | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. W. Clark 1125 Hodiamont Ave |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Jos. W. Noah

3720 Washington Ave.

Ln 7653

10 A.M. to 12 A.M.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Alfred J. Poehleker

Licensed Embalmer No. 2463

P. O. Address 1125 Hodiann

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.