

FILED **NOV 7 3 1945**
Registration District No. **2**

Primary Registration District No. **65763064**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Ferguson**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
442 Suburban Avenue.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Rufus H. Shaner.**

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 **Widowed**
6. (b) Name of husband or wife **Clara Shaner.** 6. (c) Age of husband or wife if alive **Dec'd** years
7. Birth date of deceased **September 6, 1858.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 1 24 hr. min.

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

10. Usual occupation **retired farmer.**

11. Industry or business

12. Name **William Shaner.**

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

14. Maiden name **Lucinda Fields.**

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

16. (a) Informant **Mr. Monte C. Shaner.**

(b) Address **442 Suburban Avenue.**

17. (a) **Burial** (b) Date thereof **11-2-1945.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery.**

18. (a) Signature of funeral director **Geo. L. Pleitsch, Inc.**

(b) Address **5966-68 Easton Avenue.**

19. (a) **11-2-45** (b) **E. P. Shaner M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Ferguson** **21**
(If outside city or town limits, write "RURAL")
(d) Street No. **442 Suburban Avenue.** **2**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **30** year **1945** hour **10 30** minute **2** M.

21. I hereby certify that I attended the deceased from **11-14**, 19**45** to **10-30**, 19**44**,
that I last saw him alive on **10-30**, 19**44**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial pneumonia** **10 days**
Duration

Due to **Chf nephritis** **1938**

Due to **Chf myocardial** **1935**
Other conditions **arteriosclerosis** **1920**
(Include pregnancy within 3 months of death)

Major findings: **None**
Of operations

Of autopsy **None**
Underline the cause to 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 **L**
(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) (c) Means of injury

23. Signature **Ray Johnson** (M. D. or other) **10/31/45**
Address **Ferguson Mo** Date signed

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

Clément M. McManis

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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.