No. 300
10.48

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6683

State File No. 1747

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4515 Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY 0-0
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 17 9 0
d. STREET ADDRESS (If rural, give location) 4515 Maryland

3. NAME OF DECEASED (Type or Print)
a. (First) Alva b. (Middle) B. c. (Last) Shaver

4. DATE OF DEATH (Month) Feb (Day) 23 (Year) 1949

5. SEX M 0
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan 27, 1884
9. AGE (In years last birthday) 65 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 None
11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? No

13a. FATHER'S NAME Pingree Shaver
13b. MOTHER'S MAIDEN NAME Francis Hendrics
14. NAME OF HUSBAND OR WIFE Edna Hewlett Shaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Spa. American
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Seth Plumber ADDRESS 4515 Maryland

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 15 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Arteriosclerosis
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO
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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* _____, 1939, *to* 23 Feb, 1949, *that I last saw the deceased alive on* 21 Feb, 1949, *and that death occurred at* 9:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [illegible] M.D. (Degree or title)
23b. ADDRESS 607 N Grand
23c. DATE SIGNED 24 Feb 49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Feb 26 1949
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) Madisonville (State) Ky.

DATE REC'D BY LOCAL REG. FEB 24 1949
REGISTRAR'S SIGNATURE J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE Alexander & Sons for F. S. Delmar ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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

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 Jos. E. McCulloh

Licensed Embalmer No. 2460

P. O. Address 6175 Delmar

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.