

FILED JUL 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21950**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3063** Registrar's No. **1441**

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

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>St Louis</b>	
b. CITY OR TOWN <b>CLAYTON</b>	c. LENGTH OF STAY (in this place) <b>10 yrs</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Clayton</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <b>7716 Bonhomme</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>AMANDA</b> b. (Middle) <b>LEE</b> c. (Last) <b>SHORES</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>6-16-1949</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Wp</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>6/10/1864</b>	9. AGE (In years last birthday) <b>85</b>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 15 Hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Union Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>

13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>James Shores</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Martha D. Shores</b>	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Degenerative Heart Disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Senility</b> DUE TO (c)		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>U93d</b>	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 11, 1949**, to **June 16, 1949**, that I last saw the deceased alive on **June 16, 1949**, and that death occurred at **12:42 m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>A. Susan M. D.</b> (Degree or title)	23b. ADDRESS <b>2436 Kirkham West St. Mo. 6-17-49</b>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>6/20/49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON PARK</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>
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DATE REC'D BY LOCAL REG. <b>6-18-49</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Susie Lewis</b>	ADDRESS <b>22 E. CLAYTON W. Grove</b>
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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *A. D. Richardson* .....

Licensed Embalmer No. *1928* .....

P. O. Address *2625 Glasgow* .....

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.