

FILED JUN 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18655
State File No. 4786
Registrar's No.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
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 township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 2 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2049	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Deaconess Hospital				d. STREET ADDRESS (If rural, give location) 6143 Dyson Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) AUGUSTA b. (Middle) c. (Last) SHORB			4. DATE OF DEATH (Month) (Day) (Year) May 29, 1950				
5. SEX Female /	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /		8. DATE OF BIRTH Oct. 15, 1881		9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months 7 Days 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany 4		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Poe Shorb			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Poe Shorb, 6143 Dyson Ave. St. Louis, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH						
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) Hypertension rise to the above cause (a) stating the underlying cause last. DUE TO (c)						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 231X			
22. I hereby certify that I attended the deceased from Jan. 1944, to May 29, 1950 that I last saw the deceased alive on May 29, 1950 and that death occurred at 10:30 a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. B. Sasser				23b. ADDRESS 6504a Delmar Blvd.		23c. DATE SIGNED 5-31-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-1-1950	24c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
DATE REC'D BY LOCAL REG. MAY 31 1950		REGISTRAR'S SIGNATURE J. B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAY B. SMITH, 7450 Manchester Ave. Maplewood 17, Mo.			

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

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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *Van Sizemore*

Signed.....
Student Embalmer

Licensed Embalmer No..... *4343*

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.