

FILED OCT 18 1950
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318
1003
35328
State File No. 6507

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 6507			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		d. STREET ADDRESS (If rural, give location) 4243 RUSSELL			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1				4. DATE OF DEATH (Month) (Day) (Year) July 28th, 1950					
3. NAME OF DECEASED (Type or Print) a. (First) VIOLA		b. (Middle) _____		c. (Last) SHEPHERD		4. DATE OF DEATH (Month) (Day) (Year) July 28th, 1950			
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MAR		8. DATE OF BIRTH 1912 2-29-1912			
9. AGE (In years, last birthday) 38		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Mo. D			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME GEO. DE BONNAIRE		13b. MOTHER'S MAIDEN NAME ELIZABETH YERKEY		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME CATHERINE DE BONNAIRE ADDRESS 4243 RUSSELL					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Metastatic malignancy of lungs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) type undetermined DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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) _____			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 162X							
22. I hereby certify that I attended the deceased from 6/29/50 , 19____, to 7/28/50 , 19____, that I last saw the deceased alive on 7/28/50 , 19____, and that death occurred at 5:14 pm , from the causes and on the date stated above.									
23a. SIGNATURE Joseph J. Muenster, M.D.				23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 7/29/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 7-31-50		24c. NAME OF CEMETERY OR CREMATORY LAUREL HILL		24d. LOCATION (City, town, or county) (State) St Louis Mo			
DATE REC'D BY LOCAL REG. JUL 31 1950		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schum ADDRESS 3125 Lafayette					

USE PREVIOUS EDITIONS OF THIS FORM. PRINTED AT THE MISSOURI STATE PRINTING PLANT, ST. LOUIS, MO.

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 Joe B. Rollmer

Signed.....
Student Embalmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.