

FILED NOV 13 1952

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 36834

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9837

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119 D	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3636 Page Blvd.		d. STREET ADDRESS (If rural, give location) 3636 Page Blvd.	
3. NAME OF DECEASED a. (First) John b. (Middle) Shackelford. c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 10-23-52	
5. SEX J male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed D	8. DATE OF BIRTH 11-30-'62
9. AGE (In years last birthday) 90		10. KIND OF BUSINESS OR INDUSTRY nil	11. BIRTHPLACE (City and State or Foreign Country) Mo. U
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Mary		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 ADDRESS Dorothy Thornton 3636 Page Blvd.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart Disease 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 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4201			
22. I hereby certify that I attended the deceased from 9-2-1952, to 10-23-1952, that I last saw the deceased alive on 10-21-1952, and that death occurred at 7:30 A.M., from the causes and on the date stated above.			
23a. SIGNATURE J. H. Shaker MD (Degree or title)		23b. ADDRESS 3200 Lucas Ave	
23c. DATE SIGNED 10/26/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 10-27-52	
24c. NAME OF CEMETERY OR CREMATORY St. Peters Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. OCT 27 1952		25. FUNERAL DIRECTOR'S SIGNATURE " ADDRESS Russell Und., Co. 2732 Pine Blvd	

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

James A. Carter

Licensed Embalmer No. *4681*

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.