

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12311**
Registrar's No. **2203**

FILED MAR 18 1953

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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

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 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 22 2240 Randolph	
3. NAME OF DECEASED a. (First) Isiah (Type or Print)		b. (Middle) Shackleford c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) Feb. 21 1953		5. SEX Male	
6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Nov. 25. 1902		9. AGE (In years last birthday) 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm Work	
11. BIRTHPLACE (City and State or Foreign Country) Ariz		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Chas. Shackleford		13b. MOTHER'S MAIDEN NAME Minnie Taylor	
14. NAME OF HUSBAND OR WIFE Mattie Shackleford		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Minnie Mey Chesser ADDRESS 2240 Randolph	
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) Malignant Lymphoma ANTECEDENT CAUSES DUE TO (b) Undetermined Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Agenesis of left Kidney Varices of Esophagus	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 2002		22. I hereby certify that I attended the deceased from 2-7 , 19 53 to 2-21 , 19 53 , that I last saw the deceased alive on 2-21 , 19 53 , and that death occurred at 12 N m., from the causes and on the date stated above.	
23. SIGNATURE (Degree or title) Edw. B. Williams M. D.		23b. ADDRESS 2601 N. Whittier St.	
23c. DATE SIGNED 2-24-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	
24b. DATE Feb 29-53		24c. NAME OF CEMETERY OR CREMATORY Oakdale	
24d. LOCATION (City, town, or county) (State) St Louis County Mo		25. FUNERAL DIRECTOR'S SIGNATURE J. Calhoun Smith ADDRESS St Louis County Mo	
DATE REC'D BY LOCAL REG. FEB 26 1953		REGISTRAR'S SIGNATURE J. Calhoun Smith	

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 J. L. Johnson

Licensed Embalmer No. 2698

P. O. Address 2769 Charlotte

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.