

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12680

No. 300  
10-48

FILED APR 11 1953

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

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>544</u>		Registrar's No. <u>982</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkwood</u>		c. LENGTH OF STAY (In this place) <u>25 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkwood 4683</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>460 N. Harrison Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>460 N. Harrison Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ALBERT</u> b. (Middle) <u>L.</u> c. (Last) <u>SHANDS</u>			4. DATE OF DEATH <u>April 3, 1953</u> (Month) (Day) (Year)				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 7, 1878</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u>	IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Benefit Supervisor Bell Tel. Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>Thomas J. Shands</u>		13b. MOTHER'S MAIDEN NAME <u>Ella Talmage</u>		
14. NAME OF HUSBAND OR WIFE <u>Ida Shands</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>488-03-6634</u>		
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ida Shands</u>		17. ADDRESS <u>460 N. Harrison</u>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>MEDICAL CERTIFICATION</b>			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral arterio-sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>			
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>General arterio-sclerosis</u>				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"/>		334X	
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? _____			
22. I hereby certify that I attended the deceased from <u>Jan 22, 1953</u> , to <u>April 3, 1953</u> , that I last saw the deceased alive on <u>April 2, 1953</u> , and that death occurred at <u>5 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>William B. Day, M.D.</u> (Degree or title)				23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>4-4-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>4/4/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4-4-53</u>		REGISTRAR'S SIGNATURE <u>Hubert R. Danhefer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis H. Bopp, Jr.</u>		ADDRESS <u>Kirkwood</u>	

710.

**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 Felix Husband

Licensed Embalmer No. 3034

P. O. Address Kirkwood 227

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.