

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**34537**

State File No. \_\_\_\_\_

FILED OCT 25 1953  
BIRTH NO. 53849 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 2512

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>STE. GENEVIEVE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Highway Ht.</u>	c. LENGTH OF STAY (in this place) <u>28 Days</u>	c. CITY (If outside corporate limits, write RURAL and give township): OR TOWN <u>Star Route #1, St. Genevieve, Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>Star Route #1</u> <u>0950</u> <u>1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Nancy</u> b. (Middle) _____ c. (Last) <u>Shub</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>9 - 10 - 53</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>July 30 1953</u>	9. AGE (In years last birthday) <u>1</u> if UNDER 1 YEAR Months <u>1</u> Days <u>10</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Peeryville 1960</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Wilfred Shub</u>	13b. MOTHER'S MAIDEN NAME <u>Ersula Bahr</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If you, give war or dates of service) <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Wilfred Shub, Ste. Genevieve Mo</u>	ADDRESS <u>3403</u>
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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* (a) <u>Hydrocephalus</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>meningitis</u>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>meningocele</u>		INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>3403</u>
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?

22. I hereby certify that I attended the deceased from Aug. 13, 1953, to Sept. 10, 1953, that I last saw the deceased alive on Sept. 9, 1953, and that death occurred at 2 A. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>E. E. ... MD</u>	23b. ADDRESS <u>3211 S. Grand</u>	23c. DATE SIGNED <u>9-10-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>Sept 11, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	24d. LOCATION (City, town, or county) (State) <u>St. Genevieve, 170</u>
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DATE REC'D BY LOCAL REG. <u>9/11/53</u>	REGISTRAR'S SIGNATURE <u>Herbert R. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>...</u>	ADDRESS <u>St. Genevieve Mo</u>
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WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

**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 \_\_\_\_\_

*Not*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Jerome H. Siano*

Licensed Embalmer No. \_\_\_\_\_

*3817*

P. O. Address \_\_\_\_\_

*St. Charles*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.