

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42811**
Registrar's No. **10475**

BIRTH NO. _____ 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 <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2139</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>13</u> <u>5400 Arsenal St.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>MINNIE</u> b. (Middle) <u>THATCHER</u> c. (Last) <u>SHORE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 16, 1954</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>S.</u>	8. DATE OF BIRTH <u>Sept. 19, 1865</u>
9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>27</u>	IF UNDER 24 HRS. Hour <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during usual working hours, if retired) <u>retired school teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Thomas Shore</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>		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) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <u>Miss Grace Higdon, 746 N. Forest Ave. W.G.</u>		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular accident presumably hemorrhage</u> DUE TO (b) <u>Progressive arteriosclerotic cardiovascular disease</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
INTERVAL BETWEEN ONSET AND DEATH <u>4 ds.</u> <u>15 yrs.</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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? <u>4221</u>	
22. I hereby certify that I attended the deceased from <u>Jan. 1, 1954</u> , to <u>Nov. 16, 1954</u> , that I last saw the deceased alive on <u>Nov. 16, 1954</u> , and that death occurred at <u>8:10 p. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Philip R. Gale, M.D.</u>		23b. ADDRESS <u>5400 Arsenal St.</u>	
23c. DATE SIGNED <u>11/17/54</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>Nov. 18, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Smith & Arthur J. Donnelly</u>	
26. ADDRESS <u>3840 Lindell Blvd.</u>		DATE REC'D BY LOCAL REG. <u>NOV 17 1954</u>	

(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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. M. Deaton

Licensed Embalmer No. 4699

P. O. Address 3840 Lindell

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.