

No. 300
10-48

FILED DEC 6 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40031**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **2730**

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN Clayton		c. CITY OR TOWN Univ. City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hosp.		e. STREET ADDRESS (If rural, give location) 735 Interdrive	

3. NAME OF DECEASED (Type or Print) Samuel Shipper			4. DATE OF DEATH (Month) (Day) (Year) Nov. 18-56		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH Dec. 9, 1885		9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Dry goods		11. BIRTHPLACE (City and State or Foreign Country) Austria	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Isadore Shipper		13b. MOTHER'S MAIDEN NAME Anna (unk)		14. NAME OF HUSBAND OR WIFE Gladys Shipper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gladys Shipper 735 Interdrive	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary artery thrombosis		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.		DUE TO (b) _____			
		DUE TO (c) arteriosclerotic heart disease		3 years	
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) 4200	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 **10:50** to **November 18, 56**, that I last saw the deceased alive on **Nov. 15, 1956**, and that death occurred at **11:4** m., from the causes and on the date stated above.

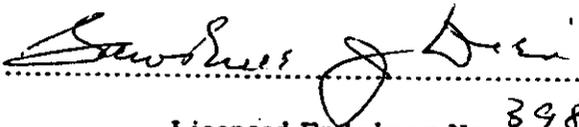
23a. SIGNATURE (Degree or title) Frank H. Fairley M.D.		23b. ADDRESS 462 No. Taylor		23c. DATE SIGNED 11/19/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 11/20/56		24c. NAME OF CEMETERY OR CREMATORY Mount Olive Hebrew	
				24d. LOCATION (City, town, or county) (State) University City Mo.	

DATE REC'D BY LOCAL REG. 11-20-56		REGISTRAR'S SIGNATURE Herbert A. Donahue MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson	
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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.....
Signature of Student Embalmer

Signed .....
Licensed Embalmer No. 398

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.