FILED MAR 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7158
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 416

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. John's — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Coral Gables — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3338 Emminence — Length of stay in Ib 7 yrs.	d. STREET ADDRESS 2401 Alhambra Circle (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
MARY	E.	SHAW	2-12-57

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
female	white		8-25-1861	95		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at home	Flat River, Mo.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George M. Williams	Permelia Thomasson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no		none	Wm. Shaw, Coral Gables, Florida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerosis generalized — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cardiac decompensation — 2 wks

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4500

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐	SUICIDE ☐	HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 10-4-55, to 2/12/57 and last saw her/him alive on 2-1-57

Death occurred at 11:48 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Henry W. Hoeller MD	Overland 14 Mo 2438 Woodson Rd	2/14/57

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
removal	2-13-57	local	Farmington, Mo.

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Cozean, Farmington, Mo.	2-14-57	Herbert A. Domke MD

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service 300 -56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Coroner, Medical Examiner: Be sure that all diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

MAR 6 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Homer W. Fri

Licensed Embalmer No. 39

P. O. Address St. S

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.