

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16771

STATE FILE NUMBER

FILED MAY 27 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 477

Health,
& Welfare
Public
Service

5. 300
7. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Portsmouth Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners Length of stay in lb 340 days		d. STREET ADDRESS Unknown (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Andrew Last Shamblee		4. DATE OF DEATH Month May Day 16th Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1899
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min. 58	IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Varied	11. BIRTHPLACE (City and state or country) Portsmouth, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Shamblee (Deceased)	
14. MOTHER'S MAIDEN NAME Lorena ? (Deceased)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address FILE: MCFP Springfield, Missouri	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency.			INTERVAL BETWEEN ONSET AND DEATH Weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bronchogenic carcinoma			Years
DUE TO (c) Atelectasis, pneumonia, etc..			??
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****		
20c. TIME OF INJURY Hour ***** Month ***** Day ***** Year ***** a. m. ***** p. m. *****	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) *****		
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION Portsmouth	COUNTY *****	STATE *****
21. I attended the deceased from 6-10-56 to 5-16-57 and last saw him him alive on 5-16-57 Death occurred at 11:45 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E. C. Rinck, M.D. (Degree or title) Clinical Director		22b. ADDRESS Medical Center for Federal Prisoners, Springfield	22c. DATE SIGNED 5-17-57
23a. BURIAL: CREATION, REMOVAL (Specify) Removal	23b. DATE 5/18/57	23c. NAME OF CEMETERY OR CREMATORY *****	23d. LOCATION (City, town, or county) (State) Portsmouth, Virginia
24. FUNERAL DIRECTOR ADDRESS AYRE-GOODWIN, Inc. Springfield		25. DATE RECD. BY LOCAL REG. 5-20-57	26. REGISTRAR'S SIGNATURE Wm. Williams

(Licensed Embalmer's Statement on Reverse Side)

1959

MAY 29 1951

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 *Lucien T. Swadlow*

Licensed Embalmer No. 1115

P. O. Address *Springfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.