

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3588

STATE FILE NUMBER

FILED JAN 13 1958

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

2

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2900 Meramec		Length of stay in lb 33-yrs.	d. STREET ADDRESS (If outside, give location) 2900 Meramec		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mother Middle Cora Last Shaw			4. DATE OF DEATH Month Jan. Day 1st. Year 1958		
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1871	9. AGE (In years at birthday) 86	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Farmington, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Philip Augustus Shaw		13b. MOTHER'S MAIDEN NAME Amelia Louise Cox		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) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mother Marie Mouton, 2900 Meramec Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Encephalopathy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 4.
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. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 Death occurred at June 1957 8:00 , to Jan 1, 1958 and last saw ^{her} him alive on 12-31-57 7/8 on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE John J. Inkle (Degree or title) John J. Inkle M.D.			22b. ADDRESS 5203 Chipmunk St. Wash. D.C.	22c. DATE SIGNED 1-1-58	
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 3, 1957	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR John J. Donnelly		ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. JAN 2 '58	26. REGISTRAR'S SIGNATURE Keith Smith Mo ms	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Francis Williamson*

Licensed Embalmer No. *3565*
P. O. Address *3840 Kinde*

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.