

health, Welfare public service  
300 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3593

STATE FILE NUMBER

FILED JAN 17 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's **370**

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>FRANKLIN</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Clair, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHNS HOSP</b>			Length of stay in lb <b>31</b>		A STREET ADDRESS (If outside, give location) <b>NONE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ELZA</b> Middle <b></b> Last <b>SHORT</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>12</b> Year <b>1958</b>					
5. SEX <b>U</b> Male		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 12, 1882</b>		9. AGE (In years last birthday) <b>76</b> IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> IF UNDER 24 HRS.: Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (City and state or country) <b>MASSELLE MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Woodson SHORT</b>				14. MOTHER'S MAIDEN NAME <b>SARAH BAY</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>493-10-8817A</b>		17. INFORMANT Address <b>HERBERT W. SHORT - House 966 Mo.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Thrombosis of popliteal artery</b>		DUE TO (c) <b>P.O. condition for carcinoma stomach</b>		?			
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.) <b>151x</b>						
20c. TIME OF INJURY Hour <b></b> Month, Day, Year a. m. <b></b> p. m. <b></b>									
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 <b>1-2-58</b> to <b>1-12-58</b> and last saw her alive on <b>1-12-58</b> Death occurred at <b>10:05 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Reginal Costello M.D.</b>					22b. ADDRESS <b>100 N. Euclid</b>		22c. DATE SIGNED <b>1-13-58</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<b>BURIAL</b>		<b>JAN 14, 1958</b>		<b>Odd Fellow Cem.</b>		<b>ST. CLAIR Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Shenwood W. Kitchell St. Clair, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 13 '58</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

JAN 23 1958

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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... *Sherrill W. Kitch*

Licensed Embalmer No... 38

P. O. Address... *St. Clair*

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