

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034702
STATE FILE NUMBER

FILED SEP 22 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8595

300-3
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
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 Missouri
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		Length of stay in lb D.O.A. 2259	d. STREET ADDRESS (If outside, give location) #5A No Ninth St.
3. NAME OF DECEASED (Type or print) First Middle Last William E. Shinkle		4. DATE OF DEATH Month Day Year Sept. 4, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 9, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Laborer	9. AGE (In years last birthday) 75
11. BIRTHPLACE (City and state or country) Cuba Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George Shinkle		13b. MOTHER'S MAIDEN NAME Martha Day	
14. NAME OF HUSBAND OR WIFE Divorced		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Raymond Shinkle Address Rt 1 Chesterfield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage DUE TO (b) Multiple Fractures DUE TO (c) E902-021 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) As a result of fall from			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Using appropriate injury in Part I or Part II (see 18b)) and fell on pavement to ground below on September 4, 1958 about 848 am at Stag Hotel #570 9th Street		
20c. TIME OF INJURY Hour Month, Day, Year 848 9 4 58	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) 25 Hotel		
20e. CITY, TOWN, OR LOCATION St Louis Mo.	20f. COUNTY STATE		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 848 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree, if M.D.) James H. Ray, M.D. ADDRESS 1300 Clark			22c. DATE SIGNED 9-5-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/8/58	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo.		25. DATE RECD. BY LOCAL REG. SEP 5 '58	26. REGISTRAR'S SIGNATURE Carl Smith M.D. m85

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 *Sheldon Collins*

Licensed Embalmer No. *3382*

P. O. Address *St. Ann*

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.