

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038483
STATE FILE NUMBER

Health,
Welfare
Public
Service

300
1-56

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. All conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 23 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2604

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Koch, Mo.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF DECEASED (NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Robert Koch Hosp.</i>		Length of stay in lb <i>79 days, 9 1/2</i>	d. STREET ADDRESS (If outside, give location) <i>4649 Pope</i>
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>E.</i> Last <i>Shingman</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>8</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 15, 1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	9. AGE (In years last birthday) <i>77</i>
13. FATHER'S NAME <i>Charles Shingman</i>		11. BIRTHPLACE (City and state or country) <i>Lincoln, Nebraska</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	14. MOTHER'S MAIDEN NAME <i>Martha Harrison</i>
17. INFORMANT <i>Koch Hospital records, Koch, Mo.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<i>493X</i>
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 checked="" type="checkbox"/> NO <input 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 _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <i>July 22, 1958</i> to <i>Oct. 8, 1958</i> and last saw him alive on <i>Oct. 8, 1958</i> Death occurred at <i>10:00</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Dr. J. J. Lane M.D.</i>		22b. ADDRESS <i>Robert Koch Hospital, Koch Mo.</i>	22c. DATE SIGNED <i>10-9-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>10-10-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Local</i>	23d. LOCATION (City, town, or county) (State) <i>West Plains, Mo.</i>
24. FUNERAL DIRECTOR <i>Albert H. Hoppe, 4700 Washington Blvd.</i>		25. DATE RECD. BY LOCAL REG. <i>10-10-58</i>	26. REGISTRAR'S SIGNATURE <i>Herbert P. Donke M.D.</i>

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OCT 7 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 *John J. Haene*
.....
Licensed Embalmer No. *41*

P. O. Address *Haene*

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.