

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042245

STATE FILE NUMBER

FILED DEC 9 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11378

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) 25 HOSPITAL OF St. Louis City Hospital # 1 INSTITUTION		Length of stay in lb		d. STREET ADDRESS (If outside, give location) 2159 4422 Oleatha Ave.	
3. NAME OF DECEASED (Type or print) First Newell Middle D. Last Shaul			4. DATE OF DEATH Month II - Day 24 - Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1884		9. AGE (In years last birthday) 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook & Baker (Retired 3 Years)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Collinsville, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Clarence L. Shaul		13b. MOTHER'S MAIDEN NAME Amelia Hoecker		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 492-14-8449		17. INFORMANT Ruth Donadon Address 4422 Oleatha Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO (b) pulmonary edema DUE TO (c) gastric ulcer, perforated PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) status post operative subtotal gastrectomy					INTERVAL BETWEEN ONSET AND DEATH
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.		540.1			
20d. INJURY OCCURRED WHILE AT <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 II/19/58 to II/24/58 and last saw ^{him} alive on II/24/58 Death occurred at 4:02 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Carl Williams, M.D.			22b. ADDRESS 1515 Lafayette Ave		22c. DATE SIGNED II/24/58
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
Cremation		Nov. 28, 1958	Missouri Crematory		St. Louis, Mo.
24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kingshighway			25. DATE RECD. BY LOCAL REG. NOV 25 '58		26. REGISTRAR'S SIGNATURE Carl Smith MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

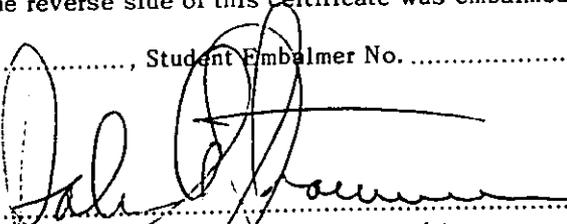
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 
Licensed Embalmer No. 4533
P. O. Address

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.