

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042246

STATE FILE NUMBER

10770

FILED NOV 20 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300

-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Chronic Hosp.</i>		Length of stay in 1b <i>2 weeks</i>	d. STREET ADDRESS (If outside, give location) <i>6926 Michigan Ave.</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle Last <i>Shaw</i>			4. DATE OF DEATH Month <i>11</i> Day <i>7</i> Year <i>58</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-20-74</i>	9. AGE (In years last birthday) <i>84</i>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (City and state or country) <i>Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>--</i>		13b. MOTHER'S MAIDEN NAME <i>--</i>		14. NAME OF HUSBAND OR WIFE <i>William Shaw</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>	17. INFORMANT Address <i>Chronic Hospital Records 5800 Arsenal St.</i>		
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>Passive Congestion of the Heart</i>					INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic Heart Disease</i>					<i>2 wks.</i>
DUE TO (c) <i>Generalized Arteriosclerosis</i>					<i>2 wks.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.0</i>					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. Month, Day, Year 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 <i>10-20-58</i> , to <i>11-7-58</i> and last saw ^{her} him alive on <i>11-7-58</i> Death occurred at <i>6:30 p.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>			22b. ADDRESS <i>5800 Arsenal</i>		22c. DATE SIGNED <i>11/8/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>11-11-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CITY CREMATORY</i>		23d. LOCATION (City, town, or county) (State) <i>Chronic Hospital, 5800 Arsenal</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Frank O'Donnell 5800 Arsenal</i>		25. DATE RECD. BY LOCAL REG. <i>NOV 10 58</i>		26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i> <i>S.P.</i>	

(Licensed Embalmer's Statement on Reverse Side)

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.

NOT EMBALMED

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No.....

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.