

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046313

STATE FILE NUMBER

FILED JAN 14 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12370

S. 300-
ev. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
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 Webster Groves		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hosp.		Length of stay in lb 1 day	d. STREET ADDRESS (If outside, give location) 729 Lexington		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN RAYMOND SHIRLEY			4. DATE OF DEATH Month Day Year Dec. 21, 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1902	9. AGE (In years last birthday) 56 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) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY S.W. Bell Tele.	11. BIRTHPLACE (City and state or country) Grand Saline, Tex.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Robert Shirley		13b. MOTHER'S MAIDEN NAME Sarah Lauderdale		14. NAME OF HUSBAND OR WIFE Pauline Shirley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 450-05-7452	17. INFORMANT Address Mrs. J. R. Shirley, 729 Lexington			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial infarction DUE TO (b) Anterior Coronary Occlusion (extensive) DUE TO (c) 420.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary extend secondary to above					INTERVAL BETWEEN ONSET AND DEATH 19 hrs. 19 hrs.	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. 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 10/24/57 to 12/20/58 and last saw him alive on 12/20/58 Death occurred at 2:30 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) John C. King MD.			22b. ADDRESS 689 E Big Bend		22c. DATE SIGNED 12/22/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-23-58	23c. NAME OF CEMETERY OR CREMATORY Sand Flat Cemetery		23d. LOCATION (City, town, or county) (State) Grand Saline, Tex.	
24. FUNERAL DIRECTOR Parker-Aldrich		ADDRESS Webster Groves		25. DATE RECD. BY LOCAL REG. DEC 22 1958	26. REGISTRAR'S SIGNATURE Carl Smith MD m f B	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

vector, carrier, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Leslie Welch*

Licensed Embalmer No. *4395*
P. O. Address *Watauga, Iowa*

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.