

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018232

STATE FILE NUMBER

FILED MAY 22 1959 Registration District No. 162 Primary Registration District No. 5544 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY JEFFERSON		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 RURAL-MERAMEC Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN ST. LOUIS 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. Joseph's Hill Infirmary Length of stay in lb 3 DAYS		d. STREET ADDRESS (If outside, give location) ALVERNE HOTEL Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last ALPHONSUS J. SHINE			4. DATE OF DEATH Month Day Year MAY 4 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 6 1889	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 71 Months 10 Days 2 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if unusual) APPRAISOR FOR ESTATE		10b. KIND OF BUSINESS OR INDUSTRY REAL INSURANCE Co.	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME DANIEL SHINE		13b. MOTHER'S MAIDEN NAME ELLEN RALEIGH		14. NAME OF HUSBAND OR WIFE ISABEL SCHAEFFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give two or dates of service) NO.		16. SOCIAL SECURITY NO. 496-36-1846		17. INFORMANT Address Bro. Conral St. Joseph's Hill Infirmary	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized ARTERIOSCLEROSIS		
	DUE TO (c) CARDIO VASCULAR DISEASE		
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

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 Month, Day, Year a.m. p.m.			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 **MAY 2 - 1959**, to **MAY 4 - 1959** and last saw ^{her} ~~him~~ alive on **MAY 4 - 1959**
Death occurred at **3:00 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. J. Marden		22b. ADDRESS St. Joseph's Hill Infirmary		22c. DATE SIGNED 5/4/59	
23a. BURIAL OR CREMATION (Specify) Removal		23b. DATE May 6, 1959		23c. NAME OF CEMETERY OR CREMATORY Capvary Cemetery	
				23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

FURNERAL DIRECTOR Arthur J. Donnelly		ADDRESS 3840 Lindell		25. DATE RECD. BY LOCAL REG. 5-5-59	
26. REGISTRAR'S SIGNATURE Robert E. Bauer					

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

MAY 22 1959

DATE RECEIVED
MAY 14 1959

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 *Ernie Williamson*

Licensed Embalmer No. *3565*

P. O. Address *3840 Lunde*

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.