

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019624

STATE FILE NUMBER

24417

FILED MAY 18 1959

Registration District No.

Primary Registration District No.

Registration No.

S. 300

1-57

0
195
0

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7600 Virginia		d. STREET ADDRESS (If outside, give location) 7600 Virginia	
3. NAME OF DECEASED (Type or print) First NELLIE Middle Last SHOULTS		4. DATE OF DEATH Month May Day 4 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At. Home	11. BIRTHPLACE (City and state or country) Illinois
13a. FATHER'S NAME Mitchell Euge		13b. MOTHER'S MAIDEN NAME Susan Mc Kinley	14. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Robert Shoults 7600 Virginia
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) arterio-sclerotic heart disease DUE TO (c) with hypertension			INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs.
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.) 420.0	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 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 Jan. 1955 to May 4, 59 and last saw her alive on May 3 - 59 Death occurred at 1:28 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) George A. O'Sullivan, M.D.		22b. ADDRESS 7629 Ivory Ave	
22c. DATE SIGNED 5-4-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE May 7, 1959	
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.		23d. LOCATION (City, town, or county) (State) Lemay 25 Mo.	
24. FUNERAL DIRECTOR ADDRESS Fendler Und. Co. 7420 Michigan		25. DATE RECD. BY LOCAL REG. MAY 5 '59	
26. REGISTRAR'S SIGNATURE Neal Smith, M.D.			

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 *W. G. Peterson*
 Licensed Embalmer No. 3767
 P. O. Address 7420 Michigan

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 *W. G. Peterson*
 Licensed Embalmer No. 3767
 P. O. Address 7420 Michigan

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.