

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023390
STATE FILE NUMBER

FILED JUL 1 1959 Registration District No. _____ Primary Registration District No. _____ Registration No. **25692**

300
1-57

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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 admission) a. STATE Missouri b. COUNTY	
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 Saint Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		Length of stay in 1b -----	d. STREET ADDRESS (If outside, give location) 2504a N. 22nd Street
3. NAME OF DECEASED (Type or print) First JAMES Middle ORLANDO Last SHAW			4. DATE OF DEATH Month June Day 12th Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 17, 1926
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laboring	9. AGE (In years at birthday) 33
11. BIRTHPLACE (City and state or country) Eldred, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Leslie Shaw		13b. MOTHER'S MAIDEN NAME Vena Hazelwood	14. NAME OF HUSBAND OR WIFE Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give major dates of service) Yes World War #2		16. SOCIAL SECURITY NO. 492-22-9852	17. INFORMANT Address Vena Hawkins, 420 Darst Road,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head.			INTERVAL BETWEEN ONSET AND DEATH 9195 43
PART II. OTHER SIGNIFICANT CONTRIBUTING CAUSES (b) Stabbing in back Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (If the nature of injury in PART I or PART II of item 18.) bit into the front of neck 1904	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 1055 p.m. June 11 1959		20d. PLACE OF INJURY (e.g. in or about home, farm, factory, street, or school, etc.) Auto - Street	
20e. CITY, TOWN, OR LOCATION St. Louis		20f. COUNTY Mo	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert Taylor Carraway		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 6.15.59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/19/59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR ADDRESS CALVIN F. FEUTZ 4828 National Bridge Bldg. FUNERAL HOME, St. Louis, 15, Missouri.		25. DATE RECD. BY LOCAL REG. JUN 15 '59	26. REGISTRAR'S SIGNATURE Keat Smith, M.D.

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 *Ralph C. Sanders*

Licensed Embalmer No. *4275*

P. O. Address *31 Fairview*

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.