DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 4 1959

2 7795 59-030785

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ALEXIAN BROS HOSP
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3122 PENNSYLVANIA
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle W Last SHAVER

4. DATE OF DEATH: Month AUG Day 20 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: MAY 3, 1881

9. AGE (last birthday): 78

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HR: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REAL ESTATE SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): ILLINOIS

12. CITIZEN OF WHAT COUNTRY: U-S-A

13a. FATHER'S NAME: PHILIP SHAVER

13b. MOTHER'S MAIDEN NAME: UNKNOWN

14. NAME OF HUSBAND OR WIFE: HENRIETTA SHAVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 488-26-8957

17. INFORMANT: HENRIETTA SHAVER Address: 3122 PENNSYLVANIA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease with auricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: one year

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 433.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.
☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

BY AFFIDAVIT OF

21. I attended the deceased from 1 May 1959 to 20 Aug. 1959 and last saw ~~her~~ him alive on 20 Aug. 1959
Death occurred at 7:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert S. Nye, M.D.

22b. ADDRESS: 3201 Arsenal St. St. Louis Mo.

22c. DATE SIGNED: 21 Aug. 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: AUG 24 1959

23c. NAME OF CEMETERY OR CREMATORY: MOUNT HOPE CEMETERY

23d. LOCATION (City, town, or county): ST. LOUIS Co. (State): MO

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: AUG 22 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.