

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**FILED VS AUG 27 1959**

**59-030786**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **2 7562**

2 7562

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b <b>40yrs</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS <b>5183 Raymond</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		e. DATE OF DEATH Month <b>8</b> Day <b>11</b> Year <b>59</b>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>Anna</b> Middle _____ Last <b>Shaw</b>			<b>4. DATE OF DEATH</b> Month <b>8</b> Day <b>11</b> Year <b>59</b>		
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11-19-1896</b>	<b>9. AGE</b> (last birthday) <b>62</b>	<b>IF UNDER 1 YEAR</b> Months <b>8</b> Days <b>23</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Elmont Missouri</b>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U S A</b>		<b>13a. FATHER'S NAME</b> <b>Sam Shepard</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Katie Henderson</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Anna Marie Shaw 5183 Raymond Ave</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>Anna Marie Shaw 5183 Raymond Ave</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>Carcinomatosis, Primary Undet.</b>			

IMMEDIATE CAUSE (a) _____  DUE TO (b) _____  DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		199.2	
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____
<b>20g. STATE</b> _____		<b>21. I attended the deceased from</b> <b>8-10-59</b> to <b>8-11-59</b> and last saw <b>her</b> alive on <b>8-11-59</b> Death occurred at <b>9:55</b> <b>P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		

<b>22a. SIGNATURE</b> (Degree or title) <i>J. R. ...</i>		<b>22b. ADDRESS</b> <b>2601 N. Whittier St.</b>		<b>22c. DATE SIGNED</b> <b>8-13-59</b>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>8-17-1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Calvary</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis</b> <b>MO</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Jas H. Randle &amp; Son 3133 Bell Ave</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>AUG 14 59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Roal Smith, M.D.</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_

Signature of Student Embalmer

Signed

*Arthur L. Heule*

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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