

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 1959

2 7611

59-030791

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>		Length of stay in 1b <b>23 DAYS</b>	c. CITY OR TOWN <b>EAST ST LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS ADMIN HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>4022 WAVERLY</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <b>JOHN</b>	Middle <b>(None)</b>	Last <b>SHOULET</b>	Month <b>AUGUST</b>	Day <b>14</b>
			Year <b>1959</b>	

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/88</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine lat</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>	11. BIRTHPLACE (City and state or country) <b>HENDERSON CO., KENTUCKY</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>ALEX SHOULET</b>	13b. MOTHER'S MAIDEN NAME <b>BARBARA PAULKNERG</b>	14. NAME OF HUSBAND OR WIFE <b>MYRPLE SHOULET</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>	16. SOCIAL SECURITY NO. <b>335-10-5061</b>	17. INFORMANT <b>VA HOSP RECORDS 915 N GRAND ST LOUIS MO</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>PULMONARY INSUFFICIENCY</b>		<b>UNKNOWN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>CHRONIC OBSTRUCTIVE EMPHYSEMA</b>	<b>UNKNOWN</b>
	DUE TO (c) <b>CHRONIC BRONCHITIS</b>	<b>UNKNOWN</b>
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 type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <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 <b>VA</b>	COUNTY	STATE
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21. I attended the deceased from <b>7/22/59</b> to <b>8/14/59</b> and last saw him alive on <b>8/14/59</b>	
Death occurred at <b>7:40 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <b>Robert M. Conati</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>VAH, ST. LOUIS, MISSOURI</b>	22c. DATE SIGNED <b>8/15/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/18/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Mem. Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Belleville, Illinois</b>
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24. FUNERAL DIRECTOR <b>John J. Keady</b> ADDRESS <b>E. St. Louis, Ill.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 17 '59</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D. (HT)</b>
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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 Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. Keady III

Licensed Embalmer No. 5039

P. O. Address Belleme

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.