

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 046332

FILED VS. JAN 11 1960 317

Primary Registration District No. 590 Registrar's No. 3515

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY ST Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Valley Park		Length of stay in lb MONS.	c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Moll Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7161 Westmoreland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ALICE Middle B. Last SHADDUCK			4. DATE OF DEATH Month Dec Day 31 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/15/1860	9. AGE (last birthday) 99	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY housewife	11. BIRTHPLACE (City and state or country) Jamestown, New York		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Joseph Bronson		13b. MOTHER'S MAIDEN NAME Rosina Warner		14. NAME OF HUSBAND OR WIFE unk.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address ZMrs. R.O. Fischer 7161 Westmoreland			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia		INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-sclerotic Heart Disease		
DUE TO (c) _____		
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.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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	COUNTY	STATE

21. I attended the deceased from **1956** to **12-31-59** and last saw her ^{her} _{him} alive on **Dec. 29 1959**
Death occurred at **8:25 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Lawrence D. Thompson M.D.		22b. ADDRESS 634 No Grand Blvd.		22c. DATE SIGNED 12-31-59
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE 12/31/59	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.	

24. FUNERAL DIRECTOR C R. Lupton and sons 7233 Delmar		ADDRESS	25. DATE RECD. BY LOCAL REG. 12-31-59	26. REGISTRAR'S SIGNATURE John E. Murphy M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Handwritten initials

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 _____

not embalmed

Licensed Embalmer No. _____

P. O. Address _____

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.