URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-028793

FILED VS AUG 4 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7159 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Lutheran Hospital | Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

c. CITY OR TOWN St. Louis | Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 7003 Minnesota | Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Della Middle Shaw Last

4. DATE OF DEATH Month July Day 16, Year 1960

5. SEX female | 6. COLOR OR RACE white | 7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐ | 8. DATE OF BIRTH Jan. 23, | 9. AGE (last birthday) 1891 69 | 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) at home | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Illinois | 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Albert Mulligan | 13b. MOTHER'S MAIDEN NAME Mary Bridge | 14. NAME OF HUSBAND OR WIFE Earl B. Shaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. unk | 17. INFORMANT Albert Chandler Address

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

IMMEDIATE CAUSE (a) Fracture of Left Hip.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Coronary Sclerosis

DUE TO (c) Interstitial Nephritis. 904.6 – 45

INTERVAL BETWEEN ONSET AND DEATH

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

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.) 305 North 7th Str. about

20c. TIME OF INJURY 510 Hour ~~a.m.~~ p.m. Month, Day, Year 6 12 60 | 510 pm., June 12 1960

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.) 25 305 N 7th St. | 20f. CITY, TOWN, OR LOCATION St. Louis, COUNTY STATE Mo.

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 6:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Salvatore E. Mylar | 22b. ADDRESS 1200 Clinton | 22c. DATE SIGNED 7/18/60

23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 7-20-60 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery | 23d. LOCATION (City, town, or county) Lemay, Mo. (State)

24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo. | 25. DATE RECD. BY LOCAL REG. JUL 18 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. arm

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

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 David Van Fossan

Licensed Embalmer No. 4242

P. O. Address St Louis

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