

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>I460 A. Belt Ave.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>I460 A. Belt Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Shaw</b> Last				4. DATE OF DEATH Month <b>12/30/60</b> Day Year					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</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>5/29/1904</b>	9. AGE (last birthday) <b>56</b>	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) <b>Cleaner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Chapman Cleaner</b>		11. BIRTHPLACE (City and state or country) <b>Dyerburg, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA.</b>		
13a. FATHER'S NAME <b>? Shaw</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Mary P. Shaw</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>489-I4-6282</b>		17. INFORMANT Address <b>Mary P. Shaw I460 A. Belt Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) <b>spontaneous pneumothorax</b> <i>Spontaneous pneumothorax</i> DUE TO (b) <b>osteomyelitis, chest wall</b> <i>osteomyelitis, chest wall</i> DUE TO (c) <b>draining sinuses, chest wall</b> <i>draining sinuses, chest wall</i>							INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>5 months</b> <b>5 months</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>renal infection</b> <i>renal infection empyema</i>					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 Month, Day, Year a.m. p.m.				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 <b>8-1-60</b> to <b>12-30-60</b> and last saw him alive on <b>12/30/60</b> Death occurred at <b>8:20 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Henry C. Dugas</i> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>3136 Easton</b>			22c. DATE SIGNED <b>12-31-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/4/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Wright Funeral Home 3100 Easton Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 3 1961</b>		26. REGISTRAR'S SIGNATURE <i>Lead 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed

*Arthur L. Hilliard*

Licensed Embalmer No. 4221  
P. O. Address 3100 Eason

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.