

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

61-016038

STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 APR 17 1961

Primary Registration District No. 590

Registrar's No. 998

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pine Lawn</u>		Length of stay in 1b <u>3 Mo.</u>	c. CITY OR TOWN <u>Normandy</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shamrock Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6988 Woodrow Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>Shaffer</u> Last <u>Shaffer</u>			4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/71</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (City and state or country) <u>Keokuk, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Henry Shaffer</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth A. Brannen</u>	
14. NAME OF HUSBAND OR WIFE <u>Jessie J. Shaffer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hal Shaffer, 6988 Woodrow Ave.</u>		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) <u>Cerebral thromboses (multiple)</u>		Interval <u>unknown</u>
DUE TO (b) <u>Auricular fibrillation</u>		Interval <u>unknown</u>
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		Interval <u>unknown</u>
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 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> <u>  </u>	

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 <u>  </u> COUNTY <u>  </u> STATE <u>  </u>
21. I attended the deceased from <u>Jan 9, 1961</u> to <u>April 9, 1961</u> and last saw him alive on <u>4/4/61</u> Death occurred at <u>10</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Lowell L. Harnman M.D.</u>	22b. ADDRESS <u>8231 Clayton Rd. (17)</u>	22c. DATE SIGNED <u>4/11/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>4/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery</u>
24. FUNERAL DIRECTOR <u>Drehmann-Harral, 1905 Union Blvd.</u>		23d. LOCATION (City, town, or county) <u>St. Louis County Mo.</u>

25. DATE RECD. BY LOCAL REG. <u>4-12-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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SHOULD READ

BY AFFIDAVIT OF

Dr. Lewis Littmann  
8231 Clayton Rd.  
Pa 7-0202  
Hrs. 3-5 Mon. & Tues.

**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 Warren A. Carver

Licensed Embalmer No. 3534

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.