

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

6857 -61-027331
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6857

FILED AUG 3 1961

1. PLACE OF DEATH a. COUNTY St. Louis Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D. O. A. Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3909 St. Louis Ave	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Richard Middle Shackelford Last			4. DATE OF DEATH Month July Day 21 Year 1961		
5. SEX Male	6. COLOR OR RACE Col	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 30 March 32 29	9. AGE (last birthday) 4 24	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing House		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A	
13a. FATHER'S NAME Albert Shackelford		13b. MOTHER'S MAIDEN NAME Hazel Mc Clenon		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			17. INFORMANT Address Mrs Hazel Shackelford 3909 St. Louis Ave		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of brain, suffered when shot with gun in hands of Police Officers in care of Homer Phillips Hospital, about 12:20 A.M., July 20, 1961		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Widow in hands of Police Officers in care of Homer Phillips Hospital, about 12:20 A.M., July 20, 1961		
DUE TO (c) Phillips Hospital, about 12:20 A.M., July 20, 1961		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 984X		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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above	
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20c. TIME OF INJURY 12:20 p.m.	Month, Day, Year 7-20-61
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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.) Street	20f. CITY, TOWN, OR LOCATION St. Louis, Mo	COUNTY	STATE
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21. I attended the deceased from 12:35 A.M. to 1:00 A.M. and last saw her/him alive on July 20, 1961. Death occurred at Phillips Hospital on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Quinn, M.D.	22b. ADDRESS 1200 Clair	22c. DATE SIGNED 7-24-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/26/61	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) St. Louis County Missouri
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24. FUNERAL DIRECTOR ADDRESS Herman J. Smith 4247 W Labadie Ave	25. DATE RECD. BY LOCAL REG. JUL 24 1961	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY A PRIMAVID OF
 SHOULD READ
 ITEM NO.

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. Herliand

Licensed Embalmer No. 4221

P. O. Address 3100 Easton Ave

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.