

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-011671
STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 559 Registrar's No. 47

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1506

24000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Festus, Mo. Joachim		Length of stay in 1b 5 days	c. CITY OR TOWN Affton, Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mountain View Conv. Home		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8609 Deming Dr.
3. NAME OF DECEASED (Type or print) First Ida Middle S. Last Shelby		4. DATE OF DEATH Month 3 Day 23 Year 62	
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 9/16/1873
9. AGE (last birthday) 88		IF UNDER 1 YEAR Months 6 Days 7	IF UNDER 24 HR Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Marshall Co., Ky.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Reilly Culp	
13b. MOTHER'S MAIDEN NAME Sarah Wyatt		14. NAME OF HUSBAND OR WIFE William Shelby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Ernest Hill		Address Affton, Mo. 8609 Deming Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH Worse 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 checked="" 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 3-18-62 to 3-23-62 and last saw her/him alive on 3-19-62 Death occurred at 6:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) [Signature]		22b. ADDRESS 112 Miss. Ave., Crystal City, Mo.	22c. DATE SIGNED 3/23/62
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 3/26/62	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Drehmann-Harral		ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. 3/23/62
26. REGISTRAR'S SIGNATURE [Signature]			

USE BLACK INK OR TYPEWRITER RIBBON

APR 10 1962

J. P. [unclear]

MAR 29 1962

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. Cawley

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.

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