

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029171

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7418

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 6 1962									
<p>1. PLACE OF DEATH</p> <p>a. COUNTY</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u> Length of stay in 1b <u>over 16 yrs</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY</p> <p>c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>3712 Cote Brilliante</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>								
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>SUSIE</u> Middle <u>SHIELDS</u> Last</p>	<p>4. DATE OF DEATH</p> <p>Month <u>July</u> Day <u>25</u> Year <u>1962</u></p>								
<p>5. SEX <u>Female</u></p> <p>6. COLOR OR RACE <u>Negro</u></p> <p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Sep. <input type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>12/26/91</u></p> <p>9. AGE (last birthday) <u>70</u></p>	<p>IF UNDER 1 YEAR</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Months	Days	Hours	Min.				
Months	Days	Hours	Min.						
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p>11. BIRTHPLACE (City and state or country) <u>Macon, Mississippi</u></p> <p>12. CITIZEN OF WHAT COUNTRY <u>America</u></p>	<p>13a. FATHER'S NAME <u>Willy Shields</u></p> <p>13b. MOTHER'S MAIDEN NAME <u>Marth Patton</u></p> <p>14. NAME OF HUSBAND OR WIFE <u>Sam Stevenson</u></p>								
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)</p> <p>16. SOCIAL SECURITY NO.</p> <p>17. INFORMANT <u>Hospital Records</u> Address</p>	<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Pneumonitis, lower lobes</u></p> <p style="text-align: center;">DUE TO (b) <u>Arteriosclerosis & hypertensive heart disease</u> years</p> <p style="text-align: center;">DUE TO (c) <u>442X</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephrosclerosis - years.</u></p> <p>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</p>								
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p> <p>20c. TIME OF INJURY Hour <u>11/19/59</u> Month, Day, Year a.m. p.m.</p> <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	<p>21. I attended the deceased from <u>11/19/59</u> to <u>7/25/62</u> and last saw her/him alive on <u>7/25/62</u></p> <p>Death occurred at <u>10:50 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p> <p>22a. SIGNATURE (Degree or title) <u>Thomas Thale</u></p> <p>22b. ADDRESS <u>5400 Arsenal St.</u></p> <p>22c. DATE SIGNED <u>7/25/62</u></p>								
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u></p> <p>23b. DATE <u>July 30/62</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson</u></p> <p>23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. MO</u></p>	<p>24. FUNERAL DIRECTOR <u>F. G. Meen</u> ADDRESS <u>4214 Delmar</u></p> <p>25. DATE RECD. BY LOCAL REG. <u>JUL 28 1962</u></p> <p>26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u></p>								

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT

DATE AMENDED

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MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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Rev. 4/59

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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 F. A. Heen

Licensed Embalmer No. 2963

P. O. Address 4214 Delman

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.