

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049947

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Registration District No. **1003** Registrar's No. **12883** STATE FILE NUMBER

| | | | |
|--|---|--|---|
| FILED JAN 6 1964 | | XC-UNKNOWN | |
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, or if institution: Residence before admission) | |
| a. COUNTY | | a. STATE MISSOURI b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | c. CITY OR TOWN ST. LOUIS | |
| Length of stay in lb 3 DAYS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, ST. LOUIS, MO. | | d. STREET ADDRESS (If outside, give location) 2828 N. JEFFERSON | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle B. Last SHAFFER | | | 4. DATE OF DEATH Month 12 Day 26 Year 63 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 11/15/18 |
| 9. AGE (last birthday) 45 | | 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) DOCK WORKER | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City, and state or country) CARUTHERSVILLE, MISSOURI, U.S.A. |
| 12. CITIZEN OF WHAT COUNTRY | | 13. NAME OF HUSBAND OR WIFE Mamie - | |
| 13a. FATHER'S NAME JAMES SHAFFER | | 13b. MOTHER'S MAIDEN NAME VIOLA MARTIN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 17. INFORMANT Address VIOLA SHAFFER (MOTHER) WARDELL, MISSOURI | |
| 16. SOCIAL SECURITY NO. WN-11 | | 17. INFORMANT Address VIOLA SHAFFER (MOTHER) WARDELL, MISSOURI | |
| 18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Myocardial Infarct | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Gastrointestinal hemorrhage and shock | | | |
| DUE TO (c) Cirrhosis of the Liver 5810 | | | |
| 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 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 <input type="checkbox"/> s.m. <input type="checkbox"/> 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. VA attended the deceased from 12/23/63 to 12/26/63 and last saw him alive on 12/26/63 . Death occurred at 11:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE [Signature] (Degree or title) M.D. | | 22b. ADDRESS VAH, ST. LOUIS, MO. | 22c. DATE SIGNED 12/26/63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 12-29-63 | 23c. NAME OF CEMETERY OR CREMATORY Local Cemetery | 23d. LOCATION (City, town, or county) (State) Wardell, Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Osburn Funeral Home, Wardell, MO. | | 25. DATE RECD. BY LOCAL REG. DEC 27 1963 | 26. REGISTRAR'S SIGNATURE [Signature] M.D. |

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

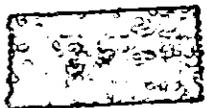
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DATE AMENDED



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 Harry E. Monroe

Licensed Embalmer No. 4495

P. O. Address St Louis, Mo

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.