

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3029**
Registrar's No. **339**

BIRTH NO. **4932-50** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 10 hrs.		d. STREET ADDRESS (If rural, give location) 22 1317 LaSalle	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Bethesda General Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) Jackie	b. (Middle) Lee	c. (Last) Shomaker	4. DATE OF DEATH (Month) (Day) (Year) Jan 11, 1950
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Jan. 11, 1950	9. AGE (In years last birthday) 10 MONTHS 7 DAYS 10 MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Bert F. Shomaker	13b. MOTHER'S MAIDEN NAME Mable Cox	14. NAME OF HUSBAND OR WIFE
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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'S SIGNATURE OR NAME Mrs. Mabel Shomaker, 1317 LaSalle	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 hours 7 minutes
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Blue Baby		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenital Atelectasis lung DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 7354
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1-11-50, 10**, to **1-11**, 19**50**, that I last saw the deceased alive on **1-11-50, 19**, and that death occurred at **5.35p m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Leroy E. Ellison M.D.	23b. ADDRESS 3610 So Broadway St Louis Mo	23c. DATE SIGNED 1-12-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-13-1950	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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DATE REC'D BY LOCAL REG. JAN 12 1950	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Leidner U. ADDRESS 2223 St. Louis Ave
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Not Embalmed
Signed *John P. Buchholz*
.....
Licensed Embalmer No. *1674*
P. O. Address *2223 St. Louis Ave*

Signed.....
Student Embalmer

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 this body is not embalmed, fact should be so stated above.