

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34730**
8286
Registrar's No. _____

BIRTH NO. _____ 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) **St. Louis**

c. LENGTH OF STAY (in this place) **40yrs.**

c. CITY (If outside corporate limits, write RURAL and give township) **St. Louis** **2119**

d. FULL NAME OF HOSPITAL OR INSTITUTION **3705 Windsor Place**

d. STREET ADDRESS (If rural, give location) **3705 Windsor Place**

3. NAME OF DECEASED
a. (First) **Louis**
b. (Middle) **B.**
c. (Last) **DeShields**

4. DATE OF DEATH (Month) (Day) (Year)
9 27 1950

5. SEX **Male**

6. COLOR OR RACE **Negro**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **6/6/1884**

9. AGE (In years last birthday) **66**
IF UNDER 1 YEAR: Months _____ Days _____
IF UNDER 24 HRS.: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Porter**

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) **Collinsville, Illinois**

12. CITIZEN OF WHAT COUNTRY? **U S A**

13a. FATHER'S NAME **Sam DeShields**

13b. MOTHER'S MAIDEN NAME **Isabelle Burnett**

14. NAME OF HUSBAND OR WIFE **Lillian DeShields**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **None**
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME **Lillian DeShields** ADDRESS **3705 Windsor Pl.**

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Ch. Myocarditis**
Ch. Nephritis
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH **2 yrs.**

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **592X**

22. I hereby certify that I attended the deceased from _____¹⁹ to **9-27, 1950** that I last saw the deceased alive on **9-27, 1950**, and that death occurred at **11:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE **E. Anna Egan M.D.** (Degree or title)

23b. ADDRESS **11730 a Page**

23c. DATE SIGNED **1 Oct 1950**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24b. DATE **10/21/50**

24c. NAME OF CEMETERY OR CREMATORY **Washington Park**

24d. LOCATION (City, town, or county) (State) **St. Louis, Missouri**

DATE REC'D BY LOCAL REG. **OCT 2 1950**

REGISTRAR'S SIGNATURE **J. B. Jansler**

25. FUNERAL DIRECTOR'S SIGNATURE **GATES FUNERAL HOME** ADDRESS **Charles J. Gates 4107 Finney**

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

John K. Cunningham

Signed.....
Student Embalmer

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.