

FILED OCT 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35605

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1005		Registrar's No. 8759			
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 town) St. Louis		c. LENGTH OF STAY (In this place) 2 weeks		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2069			
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital				d. STREET ADDRESS (If rural, give location) 5130 Highland Ave. 0					
3. NAME OF DECEASED (Type or Print) a. (First) Margaret		b. (Middle) A.		c. (Last) Shaw		4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1951			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Jan. 25, 1876		9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work dominating most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Belleville, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME William Izatt		13b. MOTHER'S MAIDEN NAME Mary Mathews		14. NAME OF HUSBAND OR WIFE Joseph H. Shaw					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME. ADDRESS Joseph H. Shaw - 5130 Highland Ave.					
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) Cardio-renal failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis of heart & kidneys DUE TO (c) Rt. Renal calculus + Renal atrophy II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Sigmoidectomy + anastomosis				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 24 Sept 51		19b. MAJOR FINDINGS OF OPERATION Pnertuberculosis of Sigmoid Colon				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 442x 584-X					
22. I hereby certify that I attended the deceased from 17 Sept, 1951, to Oct 1, 1951, that I last saw the deceased alive on Oct 1, 1951, and that death occurred at 10 P m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Dr. R. Dalton				23b. ADDRESS 4500 Olive St. St. Louis Mo 63115		23c. DATE SIGNED 9/15			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/4/51		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REG. OCT 1 1951		REGISTRAR'S SIGNATURE Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral - 1905 Union Blvd.					

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. A. R. Dalton (4-6)
Lister Bldg.

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
Student Embalmer

Signed *Warren A. Carver*

Licensed Embalmer No. *3534*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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