

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **3313**  
 Registrar's No. **0269**

FILED JAN 26 1952

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>2219</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Emroute City Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>2330 Olive St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>George</b> b. (Middle) <b>Kyle</b> c. (Last) <b>Shaver</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 5, 1952</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Sep't. 1, 1883</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months IF UNDER 11 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	11. BIRTHPLACE (State or foreign country) <b>Ashmore, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	

13a. FATHER'S NAME <b>Jonathon Shaver</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Trickey</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>A.G. Hackett, Oakland, Ill.</b>

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>arteriosclerotic heart disease with decompensation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1wk</b> <b>3wks</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Viral pneumonia</b>		
	II. 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 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? <b>H200</b>

22. I hereby certify that I attended the deceased from **1948**, to **1/4/52**, 19**52**, that I last saw the deceased alive on **1/4/52**, 19**52** and that death occurred at **4:00pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>D. S. Michael M.D.</b> (Degree or title)	23b. ADDRESS <b>812 Olive St. St. Louis Mo</b>	23c. DATE SIGNED <b>1/9/52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1-10-52</b>	24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) <b>Ashmore, Ill.</b>		

DATE REC'D BY LOCAL REG. <b>JAN 10 1952</b>	REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

3

**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 *Albert G. Happe* \_\_\_\_\_

Licensed Embalmer No. *2971* \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.