

OCT 4 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33421
8994

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2199	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3984 Delmar Blvd.-Residence		d. STREET ADDRESS (If rural, give location) 19 3984 Delmar Blvd.	
3. NAME OF DECEASED (Type or Print) Joseph Shelley		4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1952	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 25, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 61
11a. FATHER'S NAME Joseph Shelley		11b. MOTHER'S MAIDEN NAME Lacy Henderson	11c. NAME OF HUSBAND OR WIFE Dina Shelley
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12b. SOCIAL SECURITY NO. None	12c. INFORMANT'S SIGNATURE OR NAME Anna Hunter ADDRESS 3984 Delmar Blvd
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypotension DUE TO (c) 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 443X			
22. I hereby certify that I attended the deceased from Jan 1, 1952, to Sept. 24, 1952, that I last saw the deceased alive on Sept. 23, 1952, and that death occurred at 1:30 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Name or title)		23b. ADDRESS	
23c. DATE SIGNED			
24a. BURIAL, CREMATION REMOVAL (Specify) Removal		24b. DATE Sept. 30, 1952	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis, County Mo.	
DATE REC'D BY LOCAL REG. SEP 27 1952		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Earl Smith 1224 1/2 E. 12th St. St. Louis, Mo.	

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.

Student
Student Embalmer

Signed Lawrence Creams

Licensed Embalmer No. 4753

P. O. Address 1221 N. Grand

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.