

No. 300-71 ED NOV 13 1952
10-46

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36837

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9791**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. 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 2213	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If rural, give location) 2845 Delmar	

3. NAME OF DECEASED (Type or Print) a. (First) Conyers b. (Middle) Norvel c. (Last) Shaw	4. DATE OF DEATH (Month) (Day) (Year) Oct 19, 1952
------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------

5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH May 9, 1907	9. AGE (In years last birthday) 45	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 hrs. Days	12. IF UNDER 24 hrs. Hours	13. IF UNDER 24 hrs. Min.
--------------------	-----------------------------	--------------------------------------------------------	-------------------------------------	-------------------------------------------	----------------------------	---------------------------	----------------------------	---------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Brownsville Tenn	12. CITIZEN OF WHAT COUNTRY?
------------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------	------------------------------

13a. FATHER'S NAME Lavence Shaw	13b. MOTHER'S MAIDEN NAME Paralee Bonds	14. NAME OF HUSBAND OR WIFE Wm. Shaw
----------------------------------------	------------------------------------------------	---------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Chris Shaw ADDRESS 4417 Greer
--------------------------------------------------------------------------------------------------------------------	-------------------------	-------------------------------------------------------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Internal hemorrhage following stab wound of chest; suffered when stabbed with paring knife in kitchen of home 2845 Delmar	DUE TO (b) assault 340pm Oct 19 1952	
II. OTHER SIGNIFICANT CONDITIONS by wife of deceased and had (hol)	Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Justifiable Homicide	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------	--------------------------------------------------------------	----------------------------------------------------------------------------------

21a. ACCIDENT SUICIDE HOMICIDE Justifiable Homicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis MO
------------------------------------------------------------	------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 19 52 3:40 p.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? E982X
----------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------	-----------------------------------------

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **4:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Patrick E. Raylaw Coroner	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 10.24.52
-------------------------------------------------------------------	--------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Shipped	24b. DATE Oct 24/52	24c. NAME OF CEMETERY OR CREMATORY Brownsville Tenn	24d. LOCATION (City, town, or county) (State)
----------------------------------------------------------	----------------------------	------------------------------------------------------------	-----------------------------------------------

DATE REC'D BY LOCAL REG. OCT 24 1952	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE F. L. Greer ADDRESS 4214 Delmar
---------------------------------------------	-----------------------------------------------	--------------------------------------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

0

3

5

m83

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 J. G. Green.....

Licensed Embalmer No. 2963.....

P. O. Address 4214 Delaware.....

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.