

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40722

State File No.

FILED DEC 2 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10056**

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

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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)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Enroute City Hospital		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. STREET ADDRESS 1219 Amherst Pl.		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) Samuel b. (Middle) P. c. (Last) Shirley		4. DATE OF DEATH (Month) (Day) (Year) Oct. 30, 1952	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH March 7, 1874
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man	11. BIRTHPLACE (City and State or Foreign Country) Oldham Co., Ky.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Apt. House	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Robert Shirley		13b. MOTHER'S MAIDEN NAME Betty Overstreet	14. NAME OF HUSBAND OR WIFE Unknown
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. 489-09-9858	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Zula Duncan, Rt. 1, Bagdad, Ky.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension cerebral vascular ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Stroke II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19a. DATE 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 (Month) (Day) (Year) (Hour) OF INJURY	
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 6-30 , 19 52 , to 10-30 , 19 52 , that I last saw the deceased alive on 10-30 , 19 52 , and that death occurred at 10:45 a.m., from the causes and on the date stated above.			
23a. SIGNATURE Carl O. Smith M.D.		23b. ADDRESS 1194 Hodgson	
23c. DATE SIGNED 10-31-52		23d. LOCATION (City, town, or county) (State) LaGrange, Ky.	
24a. BURIAL CREMATION REMOVAL (Specify) Removal		24b. DATE 10-31-52	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. NOV 1 1952		REGISTRAR'S SIGNATURE Albert H. Hoppe	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd	

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

John J. Haines

Licensed Embalmer No. *4408*

P. O. Address *Haines MO*

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.