

OCT 15 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34045**
Registrar's No. **8961**

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 Missouri b. COUNTY _____	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 32 yrs.	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		e. STREET ADDRESS (If rural, give location) 1370a Arlington	

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) _____	c. (Last) Shackelford	4. DATE OF DEATH (Month) (Day) (Year) 9 13 53
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/27/1895	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance	11. BIRTHPLACE (City and State or Foreign Country) Ouachita, Louisiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James Shackelford	13b. MOTHER'S MAIDEN NAME Callie Carpenter	14. NAME OF HUSBAND OR WIFE Viola Shackelford
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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. 487-14-1558	17. INFORMANT'S SIGNATURE OR NAME Viola Shackelford	ADDRESS 1370a Arlington
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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		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Carcinoma		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hydrothorax; Metastasis to Pericardium, Heart, Kidneys, Liver		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 162X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-2, 1953, to 9-13, 1953, that I last saw the deceased alive on 9-13, 1953, and that death occurred at 11:55Pm., from the causes and on the date stated above.

23a. SIGNATURE E. B. Williams	(Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 9-15-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/17/53	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE SEP 16 1953 J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates	ADDRESS 4107 Finney Avenue
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No..4259....

P. O. Address 4107 Finney..

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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