

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 5 1954

State File No.

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11853

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE			b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo.		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St Louis, Mo.		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 St Marys Infirmary			e. STREET ADDRESS (If rural, give location) 4204 W. Cote Brillante			2119/8			
3. NAME OF DECEASED (Type or Print) a. (First) Josie Shannon b. (Middle) Flowers c. (Last)			4. DATE OF DEATH (Month) 12- (Day) 13- (Year) 53						
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH About 70		9. AGE (In years last birthday) About 70	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Tupelo Miss.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Joe Shannon			13b. MOTHER'S MAIDEN NAME Mattie ?			14. NAME OF HUSBAND OR WIFE P.P. Flowers			
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. No		17. INFORMANT'S SIGNATURE OR NAME Dr Helen Flowers				ADDRESS 4204 W Cote Brillante
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, asthenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Mechanical Intestinal Obstruction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diarrhea, P.O.</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>						
19a. DATE OF OPERATION 12-8-53		19b. MAJOR FINDINGS OF OPERATION <u>Mechanical (Closed Loop) Intestinal Obstruction</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) St Louis, Mo.		21d. (COUNTY) St Louis		21e. (STATE) Mo.	
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? 5705				
22. I hereby certify that I attended the deceased from 12-5, 1953, to 12-13, 1953, that I last saw the deceased alive on 12-13, 1953, and that death occurred at 1:20 P.M., from the causes and on the date stated above.									
23a. SIGNATURE <u>James M. Phillips</u>				(Degree or title)		23b. ADDRESS 824 N. Channing		23c. DATE SIGNED 12-15-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Dec 16 1953	24c. NAME OF CEMETERY OR CREMATORY Washington Park			24d. LOCATION (City, town, or county) (State) St Louis, Mo.			
DATE REC'D BY LOCAL REG. DEC 16 1953		REGISTRAR'S SIGNATURE <u>Charles Smith MD</u>			25. FUNERAL DIRECTOR'S SIGNATURE A. L. Beal Und Co. 4303 Delmar				

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 *W. Claude Gordon*.....

Licensed Embalmer No. *3489*.....

P. O. Address *4575 Ald*.....

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.