

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **45564**
Registrar's No. **12433**

FILED **93681**
JAN 19 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY 0		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 2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If rural, give location) 10 4137 Labadie 0	

3. NAME OF DECEASED (Type or Print)	a. (First) Russell	b. (Middle) Walter	c. (Last) Shaw	4. DATE OF DEATH (Month) (Day) (Year) 12 17 53
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5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 12-14-53	9. AGE (In years last birthday) 3	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 MIN. Hours _____	IF UNDER 1 MIN. Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri 0	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Robert Shaw	13b. MOTHER'S MAIDEN NAME Ruth Gilder	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Arthur M. Howard, M.D.	ADDRESS 2601 N. Whittier
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Hemolytic Anemia		INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	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.		

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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 7700
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22. I hereby certify that I attended the deceased from **12-14-1953** to **12-17-1953**, that I last saw the deceased alive on **12-17-1953** and that death occurred at **1:03 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William H. Suter, M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 12-23-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) 1-30-54	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JAN 5 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.
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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.....

Licensed Embalmer No.....

P. O. Address.....

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.