

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2318

State File No.

BIRTH NO. FILED FEB 3 1954 REG. DIST. NO. 276 PRIMARY REG. DIST. NO. 4410 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Mo b. COUNTY Phelps	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St James	c. LENGTH OF STAY (in this place) 4 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St James, Mo 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Soldiers Home Hosp.		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Belle c. (Last) Shay			4. DATE OF DEATH (Month) (Day) (Year) Jan. 27, 1954			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Oct 24, 1886	9. AGE (In years less birthday) 68	IF UNDER 1 YEAR Months 3 Days 3	IF UNDER 24 HRS. Hours Mtn.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Do not know	13b. MOTHER'S MAIDEN NAME Do not know	14. NAME OF HUSBAND OR WIFE Loren Shay
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME. ADDRESS Soldiers Home office St. James Mo
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis		
	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 type="checkbox"/> NO <input checked="" 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 (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?
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22. I hereby certify that I attended the deceased from June 16, 1953, to Jan 26, 1954, that I last saw the deceased alive on June 16, 1954, and that death occurred at H.A.M. from the causes and on the date stated above.

22. SIGNATURE (Degree or title) J. H. Grosskreutz, M.D.	23. ADDRESS St. James, Mo	23c. DATE SIGNED 1/27/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 29, 1954	24c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	24d. LOCATION (City, town, or county) (State) St. James, Mo
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DATE REC'D BY LOCAL REG. 1-28-54	REGISTRAR'S SIGNATURE Ruth B. Powell 479	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Oran E. Lickleder, St. James, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

County Health Officer,
County File Number _____
Date Filed 3-2-57

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 _____

me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Charles E. Licklider

Licensed Embalmer No. 3546

P. O. Address St James M

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.