

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44225

State File No.

FILED JAN 15 1957

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 3103

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Clayton</u>		b. COUNTY <u>St. Louis</u>	
c. LENGTH OF STAY (In this place) <u>4 years</u>		c. CITY OR TOWN <u>Clayton</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>456 Edgewood Drive</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <u>456 Edgewood Drive</u>		(If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>NELLIE</u>	b. (Middle) <u>EVELYN</u>	c. (Last) <u>SHAVER M.D.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 29, 1956</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 29, 1880</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Medical Doctor</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Moline, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jacob Hager</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Ferris</u>	14. NAME OF HUSBAND OR WIFE <u>Charles Shaver</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Gladys Adams, #15 Lake Forest</u>	ADDRESS <u>#15 Lake Forest</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Sclerosis of vessels</u> 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) <u>4201</u>
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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?
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22. I hereby certify that I attended the deceased from 12/26, 1956, to Dec, 1956, that I last saw the deceased alive on 12/26, 1956, and that death occurred at 8 1/2 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>[Signature]</u>	23b. ADDRESS <u>1150 1/2</u>	23c. DATE SIGNED <u>12/30/56</u>
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24a. BURIAL - CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Jan. 1, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	24d. LOCATION (City, town, or county) (State) <u>Moline, Illinois</u>
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DATE REC'D BY LOCAL REG. <u>12-31-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Ambruster Mortuary, 6633 Clayton Rd.</u>
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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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 478

P. O. Address St. Louis

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.