

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11065

FILED MAR 27 1957

STATE FILE NUMBER

Health,
Welfare
Public
Service

18835-57

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2073

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		Length of stay in lb	d. STREET ADDRESS 3501 Lemp		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SUSAN Middle Last SHACKLEFORD			4. DATE OF DEATH Month 2 Day 28 Year 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1957	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 36	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Lewis Shackelford			14. MOTHER'S MAIDEN NAME Katherine Gargas		
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. None	17. INFORMANT Address Lewis Shackelford, 3501 Lemp Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease of the lung					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUPLICATE TO (b) _____ DUPLICATE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 527.2					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from 2-27-57 to 2-28-57 and last saw her/him alive on 2-28-57 Death occurred at 12:10 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Wm. T. Atkinson (Degree or title) M.D.		22b. ADDRESS City Hospital		22c. DATE SIGNED 2-29-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-1-57	23c. NAME OF CEMETERY OR CREMATORY Kinder Cemetery	23d. LOCATION (City, town, or county) (State) Cuba, Mo.		
24. FUNERAL DIRECTOR Hoener Funeral Home, Cuba, Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 1 '57	26. REGISTRAR'S SIGNATURE Paul Smith MD <i>mjs</i>	

Securing the medical certification in the precise manner required by the State is the responsibility of the coroner, doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Missouri

x

St. Louis

1915

x

3201 Lehigh

ST. LOUIS, MISSOURI

23 23

St. Louis

St. Louis

38

St. Louis, Mo.

xx

White

Female

2.0

St. Louis, Mo.

None

Katherine Gardner

Lewis Backelof

3201 Lehigh Av.

None

No

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

John J. Haines

Licensed Embalmer No. 4108

P. O. Address *St. Louis, Mo.*

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.

Home Funeral Home, St. Louis, Mo.