

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

58-020148
State File No.

FILED MAY 23 1958

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 5179	
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, write RURAL and give town) St. Louis.		c. LENGTH OF STAY (in this place) 7-Days.		c. CITY OR TOWN St. Louis,		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) St. Louis Chronic Hospital.				e. STREET ADDRESS (If rural, give location) 1964 A. Burd.			
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) _____		c. (Last) Short.		4. DATE OF DEATH (Month) (Day) (Year) May 15, 1958	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH July 10 1875	
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months 9 Days 26		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (City and State or Foreign Country) Mo. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown.			13b. MOTHER'S MAIDEN NAME Unknown.			14. NAME OF HUSBAND OR WIFE Dollie Short.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Selma Louisa Morelle			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio Vasc. Dis.				INTERVAL BETWEEN ONSET AND DEATH 7 days.	
*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) Generalized arteriosclerosis				7 days.	
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 443x				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (COUNTY) (STATE) _____			
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? _____			
22. I hereby certify that I attended the deceased from May 8, 1958 , to May 15, 1958 , that I last saw the deceased alive on May 15, 1958 , and that death occurred at 5:15 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.				23b. ADDRESS 5800 Arsenal		23c. DATE SIGNED 5/16/58	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 18 1958		24c. NAME OF CEMETERY OR CREMATORY Odd Fellow Cemetery		24d. LOCATION (City, town, or county) (State) St. Clair Mo.	
DATE REC'D BY LOCAL REG. MAY 16 58		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Sherrard W. Kitchell		ADDRESS St. Clair Mo.	

S.P.

(Licensed Embalmer's Statement on Reverse Side)

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..... *Shenwood W. Kitchel*

Licensed Embalmer No. *387*

P. O. Address *St. Clair,*

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.