

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038209

STATE FILE NUMBER

OCT 27 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9574

S. 300
1-57

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Clayton 4442
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		Length of stay in 1b 2 weeks	d. STREET ADDRESS (If outside, give location) 8132 Roxburgh Dr.
3. NAME OF DECEASED (Type or print) First MIDDLE Last HERBERT SHAMP			4. DATE OF DEATH Month Day Year October 4, 1958
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1875
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		9b. KIND OF BUSINESS OR INDUSTRY Structural Steel	9. AGE (In years last birthday) 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Structural Steel	11. BIRTHPLACE (City and state or country) Fairfield, Iowa
13a. FATHER'S NAME Shamp		13b. MOTHER'S MAIDEN NAME Ellen Gaither	12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 488-05-3341	14. NAME OF HUSBAND OR WIFE Myrtle Shamp, Deceased
17. INFORMANT Address A Miss Helen Shamp, 8132 Roxburgh Dr.			17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prostatic Hypertrophy Benign</u>			INTERVAL BETWEEN ONSET AND DEATH 1 Week
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 Month, Day, Year 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 <u>9-17-58</u> to <u>10-4-58</u> and last saw her alive on <u>10-4-58</u> Death occurred at <u>1:40 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Edward J. Becker MD.</u>		22b. ADDRESS <u>906 Olive St. Louis 1 Mo</u>	22c. DATE SIGNED <u>10-6-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-7-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Stock Mortuary, 889 S. Brentwood</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 6 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD.</u>

J. Carl Smith MD.
MSB

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 *Herbert J. Lane Jr.*

Licensed Embalmer No. *4800*

P. O. Address *Hicksville, N.Y.*

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.