

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019932

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1342

AMENDED

FILED JUN 6 1961

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Length of stay in lb DOA	c. CITY OR TOWN <b>Overland</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Louis Co Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2222 Dawes</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Leroy</b> Middle <b>J.</b> Last <b>Shatro</b>			4. DATE OF DEATH Month <b>5</b> Day <b>11</b> Year <b>1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/28/1922</b>
9. AGE (last birthday) <b>38</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b>	IF UNDER 24 HR Hours <b>13</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. St Louis Co Highway</b>	11. BIRTHPLACE (City and state or country) <b>St Charles, Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Irwin Shatro</b>	
13b. MOTHER'S MAIDEN NAME <b>Mable Sanders</b>		14. NAME OF HUSBAND OR WIFE <b>Ida Shatro</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT Address <b>Ida Shatro 2222 Dawes Overland, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures of the skull and other internal injuries; associated asphyxia</b> DUE TO (b) <b>asphyxia</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Trapped in cave-in of excavation while washed-out culvert was being repaired</b>	
20c. TIME OF INJURY Hour <b>10:00</b> a.m. Month, Day, Year <b>5/11/61</b>		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <b>public road</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>Missouri</b> STATE
21. I attended the deceased from <b>10:58 A</b> to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Raymond H. Hahn</i> (Degree or title) <b>Coroner</b>		22b. ADDRESS <b>Clayton, Mo.</b>	22c. DATE SIGNED <b>5/17/61</b>
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/15/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fee-Fee Cemetery</b>
23d. LOCATION (City, town, or county) <b>St Louis Co.</b>		23e. (State) <b>Mo</b>	
24. FUNERAL DIRECTOR <b>Ortmann F Home</b>		25. DATE RECD. BY LOCAL REG. <b>5-13-61</b>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy</i>
ADDRESS <b>9222 Lackland Overland Mo</b>			

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1961 JUN 9 SA

JUN 13 1961

**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 Al. C. Ostmann

Licensed Embalmer No. 3478

P. O. Address \_\_\_\_\_

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.