

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-031443

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2479

AMENDED

FILED SEP 13 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 1b <b>1 day</b>		c. CITY OR TOWN <b>University City</b>		Inside Limits Yes <input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6650 Waterman</b>	
3. NAME OF DECEASED (Type or print) <b>DR. EUGENE</b>		First		Middle <b>LEE</b>		Last <b>SHRADER</b>	
4. DATE OF DEATH <b>Sept 1, 1961</b>		Month		Day		Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>5/24/1961</b>		9. AGE (last birthday) <b>63yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practicing Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (City and state or country) <b>Moberly, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Dr. Eugene W. Shrader</b>			13b. MOTHER'S MAIDEN NAME <b>May Thomas</b>			14. NAME OF HUSBAND OR WIFE <b>Eugenia Martin Shrader</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW-1</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Eugenia M Shrader 6650 Waterman</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>Asphyxia - Pulmonary Fibrosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Pulm TB.</b> DUE TO (c) <b>Pulm TB.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 + hrs</b> <b>10 yrs.</b> <b>20 yrs</b>	
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 checked="" type="checkbox"/> NO <input 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 a.m. p.m.		Month, Day, Year					
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 <b>8/31 1:20 AM</b> to <b>9/1</b> and last saw her/him alive on <b>8/31/61</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Ra Kusella MD</b>				22b. ADDRESS <b>3720 Washington</b>		22c. DATE SIGNED <b>9/1/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Sept 4, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Moberly, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>ALEXANDER &amp; SONS 6175 Delmar</b>				25. DATE RECD. BY LOCAL REG. <b>9-4-61</b>		26. REGISTRAR'S SIGNATURE <b>John B. Murphy MD</b>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Ralph Kinsella  
3720 Washington  
Je3 5100  
at 2:30

**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 J. Allen Davison

Licensed Embalmer No. 4903

P. O. Address Albany

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.