

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

XC-1563 431

SL 27602

=62-008718

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1805**

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 23 1962

a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
		a. STATE <b>Missouri</b>	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. Grand, St. Louis, Mo.</b>	Length of stay in lb <b>17 days</b>	c. CITY OR TOWN <b>Stoutland</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS	(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>ARTIE</b>	Middle <b>L.</b>	Last <b>SHAHA</b>	4. DATE OF DEATH	Month <b>February</b>	Day <b>9</b>	Year <b>1962</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/12/86</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR	IF UNDER 24 HR
			Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Stoutland, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>BEN SHAHA</b>	13b. MOTHER'S MAIDEN NAME <b>MARY SEYBOLD</b>	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT <b>Clyde Gideon (Cousin), Same add. as 2.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>MASSIVE BRONCHO PNEUMONIA, BIL. WITH LEFT EMPYEMA</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	<b>491x</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>G.A.S., MARKED WITH A.S.H.D.</b>		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
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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.)
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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
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21. I attended the deceased from <b>1/23/62</b> to <b>2/9/62</b> and last saw him alive on <b>2/9/62</b>
Death occurred at <b>4:35 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>SANFORD WOLFSON M.D.</b>	22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>2/9/62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2-13-62</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) <b>Lebanon, Mo.</b>	(State)
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24. FUNERAL DIRECTOR <b>Southern Funeral Home</b>	ADDRESS <b>6322 S. Grand, St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 12 1962</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59	
1	
2	<b>0150, 16</b>
3	
4	<b>0</b>
5	<b>3</b>
6	
7	<b>0</b>
8	<b>1</b>
9	
10	
11	
12	<b>93-0</b>
13	

**83**

**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 James C. Hill

Licensed Embalmer No. 4347  
P. O. Address 6322 So Grand

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.