

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038032  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9201**

FILED SEP 19 1963

VS 300  
Rev. 4/59.

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

DATE AMENDED  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>15 yrs.</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE <b>Mo.</b>		b. COUNTY		d. STREET ADDRESS (If outside, give location) <b>4755 a Cote Brilliante</b>		Reside on Farm <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First Middle Last <b>Fannie A. Shaiper</b>			4. DATE OF DEATH Month Day Year <b>9 12 63</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8/3/92</b>		9. AGE (last birthday) <b>71</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Branch Manager-Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>		11. BIRTHPLACE (City and state or country) <b>Plainview, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>John W. Faragher</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Ellen Donahue</b>			14. NAME OF HUSBAND OR WIFE <b>J. D. Shaiper</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)			16. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Mrs. Ruth Brown, 4755a Brilliante Cote</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>myocardial infarction</b>									<b>minutes</b>	
DUE TO (b) <b>Arterioscl. heart disease</b>									<b>6 yrs.</b>	
DUE TO (c) <b>420.0</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 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>July 6, 57</b> to <b>Sept. 63</b> and last saw her alive on <b>Sept. 3, 63</b> Death occurred at <b>7:10 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>Melvin C. Joesman, MD</b>				22b. ADDRESS <b>63K n. Grand, St. L., Mo.</b>				22c. DATE SIGNED <b>9/13/63</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>9/14/63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis County</b>		STATE <b>Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Drehmann-Harral 1905 Union</b>			25. DATE RECD. BY LOCAL REG. <b>SEP 13 1963</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>					

Dr. Melvin L. Goldman  
634 N. Grand  
Je. 5-1113

Hrs. 1-5 FNI

**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 Albert P. Thompson

Licensed Embalmer No. 4657

P. O. Address H. Jones

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.