

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049949

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12440

FILED DEC 20 1963

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>77 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Anthony Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3453 Dunnica St.</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>BERTHA</u> Last <u>SHANNAHAN</u>			4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1963</u>			5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17, '86</u>		9. AGE (last birthday) <u>77 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>George Doermer</u>						13b. MOTHER'S MAIDEN NAME <u>Emma Katherine Kauffman</u>						14. NAME OF HUSBAND OR WIFE <u>James W. Shannahan</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>						17. INFORMANT Address <u>Mr. Roy G. Shannahan, 3453 Dunnica St. (18)</u>							
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) <u>Myocardial infarct (posterior) acute</u>												<u>2 days</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												DUE TO (b) <u>Arteriosclerotic heart disease</u>				<u>1 yr.</u>			
												DUE TO (c) <u>Diabetes mellitus</u>				<u>15 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>260x</u>												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 <u>11.22.57</u> to <u>12.15.63</u> and last saw her/him alive on <u>12.15.63</u> Death occurred at <u>2:10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <u>[Signature]</u> M.D.						22b. ADDRESS <u>3654 S. Grand Blvd.</u>				22c. DATE SIGNED <u>12.16.63</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Dec. 18, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>				23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>											
24. FUNERAL DIRECTOR ADDRESS <u>Beiderwieden F.H.Inc., 3620 Chippewa (16)</u>						25. DATE RECD. BY LOCAL REG. <u>DEC 16 1963</u>		26. REGISTRAR'S SIGNATURE <u>[Signature] M.D.</u>											

Dr. Carlo Cascio
3654 So. Emerald
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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 Homer H. Fritz

Licensed Embalmer No. 3882

P. O. Address So. Emerald

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.