

FILED NOV 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38482

State File No.

| | | | | | | | | | | | | | | | | |
|---|-----------------|--|---|--|---|---|--|-----------------|-----------------|-----------------|--------|------|-------|--|--|--|
| BIRTH NO. | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 9261 | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Montgomery | | | | | | | | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jonesburg | | 0760 | | | | | | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital | | | | d. STREET ADDRESS (If rural, give location) ----- | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Cytha b. (Middle) Duncan c. (Last) Fleahman | | | 4. DATE OF DEATH (Month) (Day) (Year) October 31, 1950 | | | | | | | | | | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH June 24, 1899 | | 9. AGE (In years last birthday) 51 | <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 1 YEAR</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table> | IF UNDER 1 YEAR | IF UNDER 1 YEAR | IF UNDER 1 YEAR | Months | Days | Hours | | | |
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| Months | Days | Hours | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Bellflower, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 13a. FATHER'S NAME Charles E. Shelton | | 13b. MOTHER'S MAIDEN NAME Sallie Gardner | | 14. NAME OF HUSBAND OR WIFE William Fleahman | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Fleahman, Jonesburg, Mo. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | <p align="center">MEDICAL CERTIFICATION</p> <p>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of liver</p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of left breast</p> <p>DUE TO (c)</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p> | | | | | <p>INTERVAL BETWEEN ONSET AND DEATH 6 mo. 5 d.</p> <p>2 yrs.</p> | | | | | | | | | |
| 19a. DATE OF OPERATION 2 yrs. ago | | 19b. MAJOR FINDINGS OF OPERATION Carcinoma of left breast. | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | | | | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 1'10K | | | | | | | | | | | | |
| 22. I hereby certify that I attended the deceased from Oct 13, 1950 , to Oct 31, 1950 , that I last saw the deceased alive on Oct 30, 1950 , and that death occurred at 5:10 a.m. , from the causes and on the date stated above. | | | | | | | | | | | | | | | | |
| 23a. SIGNATURE Robert E. Koch (Degree or title) 0 | | | | 23b. ADDRESS 35N. Central Ave. | | 23c. DATE SIGNED 10.31.50 | | | | | | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 10-31-50 | 24c. NAME OF CEMETERY OR CREMATORY Jonesburg Cemetery | | 24d. LOCATION (City, town, or county) (State) Jonesburg, Missouri | | | | | | | | | | | |
| DATE REC'D BY LOCAL REG. OCT 31 1950 | | REGISTRAR'S SIGNATURE J. B. Foster | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hopp 4700 Washington | | | | | | | | | | | | |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 29 1955

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *John B. Bankley*
Licensed Embalmer No. *3653*

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 this body is not embalmed, fact should be so stated above.