

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35958

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8927

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY OR TOWN Imperial	
c. LENGTH OF STAY (In this place) 4 weeks		e. STREET ADDRESS (If rural, give location) 0306 / 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Park Lane Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) EDITH b. (Middle) IRENE c. (Last) SHANE			4. DATE OF DEATH (Month) (Day) (Year) 9-29-54
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 6-8-1924
9. AGE (In years last birthday) 30		IF UNDER 1 YEAR Months Days	IF OVER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during usual working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Clarkton, Mo.
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Garnett G. Gray		13b. MOTHER'S MAIDEN NAME Lola Robinson	14. NAME OF HUSBAND OR WIFE Wayne Shane
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wayne Shane, Imperial, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of uterus with cerebral metastasis		INTERVAL BETWEEN ONSET AND DEATH 9 mos	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		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) 174 X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6-3-, 1954, to 9-29, 1954, that I last saw the deceased alive on 9-28, 1954, and that death occurred at 12:40 a.m., from the causes and on the date stated above.			
23a. SIGNATURE Rosemary R. Larkin M.D.		23b. ADDRESS 3284 Swank	23c. DATE SIGNED 30 Sept
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 9-30-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Gideon, Mo.
DATE REC'D BY LOCAL REG. OCT 1 1954	REGISTRAR'S SIGNATURE Carl Smith MO	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell F.H., Gideon, Mo.	

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

UCJ 26 1111

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.....

John D. ...

Licensed Embalmer No. *405*

P. O. Address *Sh. P.*

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.