

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038210

STATE FILE NUMBER 8967

60348-38  
FILED OCT 20 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN St LOUIS Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St LOUIS 21 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St LUKES HOSPITAL Length of stay in 1b 32		d. STREET ADDRESS (If outside, give location) 9240 SUNDOWN Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BABY SHANKS			4. DATE OF DEATH Month 8 Day 9 Year 58
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-9-58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 5 30
11. BIRTHPLACE (City and state or country) St LOUIS Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID F SHANKS		14. MOTHER'S MAIDEN NAME JOYCE WIEMANN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT DAVID F SHANKS		Address 9240 SUNDOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pre mature 20 wks Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 776x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 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
21. I attended the deceased from 5/9/59 to 8/9/59 and last saw her alive on 8/9/59. Death occurred at 5 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R. L. Sunderman M.D.		22b. ADDRESS 4943 North Bridge	22c. DATE SIGNED 8/9/58
23a. BURIAL, CREMATION REMOVAL (Specify) 9-30-58	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. GENERAL DIRECTOR ADDRESS Rowland-Aker 4104 Manhattan		25. DATE RECD. BY LOCAL REG. SEP 17 1958	26. REGISTRAR'S SIGNATURE Carl Smith MD

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS  
I hereby certify that the body of \_\_\_\_\_  
deceased \_\_\_\_\_  
was embalmed by \_\_\_\_\_  
Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.  
Signed \_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_  
P. O. Address \_\_\_\_\_

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.