

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003475

STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. Primary Registration District No. Registrar No. 856

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPR. #1		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3427 S. Jefferson
3. NAME OF DECEASED (Type or print) First Middle Last LENA SCHENK		4. DATE OF DEATH Month Day Year JAN. 23, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 70
11. BIRTHPLACE (City and state or country) Illinois /		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME August Sherman		13b. MOTHER'S MAIDEN NAME Eva Schimpf	14. NAME OF HUSBAND OR WIFE Peter Schenk
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 Address Mabel Schenk 3427 S. Jefferson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PLEURAL EFFUSION			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARCINOMA OF THE BREAST			
DUE TO (c) 170X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1
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.	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 1/21/59 , to 1/23/59 and last saw her/him alive on 1/23/59 Death occurred at 2:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Lloyd F. Walk, M.D.		22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 1/24/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-26-1959	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) (State) Murphysboro, Ill.
24. FUNERAL DIRECTOR ADDRESS Crawshaw- Murphysboro, Ill.		25. DATE RECD. BY LOCAL REG. JAN 26 '59	26. REGISTRAR'S SIGNATURE Carl Smith MD m d B

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

6931 38 842

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 *Clarence M. Billo*

Licensed Embalmer No. *4375*
P. O. Address *St. Louis, Mo.*

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.