

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-014830

STATE FILE NUMBER

AMENDED **F**

Registration District No. **310**

Primary Registration District No. **3058**

Registrar's No. **88**

|   |                                    |  |  |
|---|------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. CHARLES</b>   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>ST. CHARLES</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. CHARLES</b>                | Length of stay in 1b <b>18 YRS</b> | c. CITY OR TOWN <b>ST. CHARLES</b>   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH HOSP.</b> |                                    | d. STREET ADDRESS (If outside, give location) <b>11 EAYE</b>   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                           |   |   |  |  |
|--|---------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>CHARLES VIRGIL SHANKS</b>  |                           |   | 4. DATE OF DEATH Month Day Year<br><b>APRIL 6 1961</b>            |  |  |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>MAY 30 1898</b>                               | 9. AGE (last birthday) <b>60</b>                           | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HIGHWAY MAINTENANCE</b>    |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>COUNTY HY. DEPT. BENJAMIN, MO</b>  | 11. BIRTHPLACE (City and state or country) <b>Mo</b>              | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>                  |  |
| 13a. FATHER'S NAME <b>JOHN W SHANKS</b>  |                           | 13b. MOTHER'S MAIDEN NAME <b>MARY F. WALL</b>   |   | 14. NAME OF HUSBAND OR WIFE <b>MILDRED SHERWOOD SHANKS</b> |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES W.W.I</b> |                           |   | 17. INFORMANT Address<br><b>MILDRED S SHANKS, ST. CHARLES, MO</b> |  |  |

|   |   |  |
|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |   | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Carcinoma head of pancreas</b>   |   | <b>18 months</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Gastrointestinal Hemorrhage</b> | <b>36 hours</b>  |
|   | DUE TO (c) <b>Carcinoma metastatic cecum</b>  | <b>6 months</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

|  |   |  |
|--|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>2/18/60</b> , to <b>4/6/61</b> and last saw her/him alive on <b>4/6/61</b><br>Death occurred at <b>10:20</b> a. m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |

|  |                                       |   |
|--|---------------------------------------|---|
| 22a. SIGNATURE (Degree or title)<br><b>Russell Glider M.D.</b> | 22b. ADDRESS<br><b>St Charles, Mo</b> | 22c. DATE SIGNED<br><b>April 8, 1961</b>                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>    | 23b. DATE<br><b>APRIL 8 1961</b>      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LAKE CHARLES MEM. PARK</b>         |
| 24. FUNERAL DIRECTOR<br><b>C.L. PRINSTER</b>                   | ADDRESS<br><b>ST. CHARLES, MO</b>     | 23d. LOCATION (City, town, or county) (State)<br><b>ST. LOUIS COUNTY Mo</b> |
| 25. DATE RECD. BY LOCAL REG.<br><b>April 8, 1961</b>           |                                       | 26. REGISTRAR'S SIGNATURE<br><b>Marcella Wilson</b>                         |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 10 1961

APR 19 1961

**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 Howard O Kessler

Licensed Embalmer No. 4631

P. O. Address Wentzville

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.