

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9627** -61-039217
 FILED OCT 26 1961 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MISSOURI</i>		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Illinois</i> b. COUNTY <i>ST. CLAIR</i>		c. CITY OR TOWN <i>EAST ST. LOUIS</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>CARDINAL GLENNON</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>2107 BAKER</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>SHARON Denise SHANKLIN</i>			4. DATE OF DEATH Month Day Year <i>10 - 16 - 61</i>						
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>8/15/59</i>	9. AGE (last birthday) <i>2 Yrs</i>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>INFANT</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (City and state or country) <i>ST. LOUIS, MO.</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>			
13a. FATHER'S NAME <i>William Shanklin</i>		13b. MOTHER'S MAIDEN NAME <i>Mae Frances Blackburn</i>		14. NAME OF HUSBAND OR WIFE <i>None</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mae Frances Shanklin, 2107 Baker</i>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC RETINOBLASTOMA</i>					INTERVAL BETWEEN ONSET AND DEATH <i>6-8 mos.</i>				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <i>8-25-61</i> to <i>10-16-61</i> and last saw ^{her} him alive on <i>10-16-61</i> Death occurred at <i>11³⁰ PM</i> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Daniel D. O'Sullivan, M.D.</i>				22b. ADDRESS <i>1425 So. GRAND.</i>			22c. DATE SIGNED <i>10-17-61</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/20/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sunset Gardens</i>		23d. LOCATION (City, town, or county) (State) <i>Stokey Township, Illinois</i>				
24. FUNERAL DIRECTOR <i>Margaret Greer</i>		ADDRESS <i>2114 Missouri Ave. E. ST. LOUIS, ILL.</i>		25. DATE RECD. BY LOCAL REG. <i>OCT 18 1961</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

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 Frank Prokopp

Licensed Embalmer No. 4356

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.