MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 230 — 62-003643 STATE FILE NUMBER

FILED JAN 11 1962

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LUKES HOSPITAL — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: ST. LOUIS
c. CITY OR TOWN: LADUE — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): # 1 WARSON TERRACE — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First LYSTA Middle — Last DANIEL
4. DATE OF DEATH: Month Jan. Day 6 Year 1962
5. SEX: female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8/2/1884
9. AGE (last birthday): 77 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (City and state or country): Hogansville, GA.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Plesant Ware
13b. MOTHER'S MAIDEN NAME: Tommie Melson
14. NAME OF HUSBAND OR WIFE: H.O. Daniel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Sam Clement; Address: 1 Warson Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic adenocarcinoma — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ~~DUE TO (b)~~ of breast — 3 yrs 4 mos
DUE TO (c) 170 X
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 14 Nov '46 to 6 Jan '62 and last saw her/him alive on 5 Jan '62
Death occurred at 4:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Truman G. Drake, M.D. (Degree or title)
22b. ADDRESS: 114 N. Taylor, St. L. 8
22c. DATE SIGNED: 6 Jan '62

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 1/7/1962
23c. NAME OF CEMETERY OR CREMATORY: Westview Cemetery
23d. LOCATION (City, town, or county) (State): Alanta, Georgia
24. FUNERAL DIRECTOR: C.R. Lupton & Sons; ADDRESS: 7233 DElmar Blvd
25. DATE RECD. BY LOCAL REG.: JAN 6 1962
26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

Doctor's office will call

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 Arnold W. Schoene

Licensed Embalmer No. 3864

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.