

FILED MAY 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16137**
1896

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY Howard			
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (in this place) 6 days		c. CITY (If outside corporate limits, write RURAL and give township) Fayette			
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) THELMA			b. (Middle) R.		c. (Last) SHREINER		4. DATE OF DEATH (Month) (Day) (Year) 4 30 49
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH April 29, 1906	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dean of Women		10b. KIND OF BUSINESS OR INDUSTRY Central College		11. BIRTHPLACE (State or foreign country) Pa. Marietta, Lancaster Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Clayton Shreiner			13b. MOTHER'S MAIDEN NAME Annie Eshelman		14. NAME OF HUSBAND OR WIFE XX		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No XX		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Anna Lippy, Harrisburg, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION, DIRECTLY LEADING TO DEATH* (a) Tumor of Brain - Malignant ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 1937				INTERVAL BETWEEN ONSET AND DEATH 6 Mos.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Tumor of Brain glioblastoma Multiforme, L. Frontal Lobe				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr 24, 1949 , to Apr 30, 1949 , that I last saw the deceased alive on Apr 30, 1949 , and that death occurred at 3:00 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Donald F. Coburn, M.D.				23b. ADDRESS 411 Alameda Rd. Kansas City 2, Mo.		23c. DATE SIGNED 4-30-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-1-49		24c. NAME OF CEMETERY OR CREMATORY Hanover, Cemetery		24d. LOCATION (City, town, or county) (State) Hanover, Pa.	
DATE REC'D BY LOCAL REG. 4-30-49		REGISTRAR'S SIGNATURE Seraldine Holmes			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. Wagner, Kansas City Mo		

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 22 1949

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at a
name
the

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
Student Embalmer

Signed

Eugene L. Kemmer

Licensed Embalmer No.

4633

P. O. Address

Kansas City, 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 this body is not embalmed, fact should be so stated above.