

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32134

State File No.

FILED OCT 13 1951

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 4465 Registrar's No. 3367

1. PLACE OF DEATH a. COUNTY St. Louis County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rock Hill		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rock Hill 4631	
c. LENGTH OF STAY (In this place) 2 yrs		d. STREET ADDRESS (If rural, give location) 1104 Rockman 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1104 Rockman			

3. NAME OF DECEASED (Type or Print) ALICE ANN PLANK	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 10-5-51
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1884 4-16-1880	9. AGE (In years last birthday) 67 5 Months 19 Days	10. UNDER 1 YEAR Hours Min.	11. UNDER 10 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd. Housewife	10b. KIND OF BUSINESS OR INDUSTRY X X X X X X	11. BIRTHPLACE (State or foreign country) Iberia, Mo.	12. CITIZENRY OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Allen Shackelford	13b. MOTHER'S MAIDEN NAME Nancy Smith	14. NAME OF HUSBAND OR WIFE Jack Plank
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Edith M. Belk	ADDRESS Above
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis with decompensation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of uterus		4 years	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 9/30, 1951, to 10/5, 1951, that I last saw the deceased alive on 10/4, 1951, and that death occurred at 10:25 m., from the causes and on the date stated above.

23a. SIGNATURE Spencer M. Spence M.D.	(Degree or title)	23b. ADDRESS 1456 Manchester	23c. DATE SIGNED 10/8/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-9-51	24c. NAME OF CEMETERY OR CREMATORY Park Lawn Ceme.	24d. LOCATION (City, town, or county) (State) St. Louis, Co.
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DATE REC'D BY LOCAL REG. 10-8-51	REGISTRAR'S SIGNATURE Herbert P. Bomke	25. FUNERAL DIRECTOR'S SIGNATURE Jay B. Smith	ADDRESS Funeral Home 1456 Manchester Maplewood 17, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Felix Durand

Licensed Embalmer No. 3034

P. O. Address Kirkwood 22

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.