

## STANDARD CERTIFICATE OF DEATH

State File No. 10427

FILED DEC 2 1952

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10427

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maryville	
d. FULL NAME OF HOSPITAL OR INSTITUTION Marian Hospital		d. STREET ADDRESS (If rural, give location) Rural Route	

3. NAME OF DECEASED (Type or Print) Gertrude		a. (First)		b. (Middle)		c. (Last) Yankausky		4. DATE OF DEATH (Month) (Day) (Year) 11-10-52		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 1-11-1894		9. AGE (In years last birthday) 58		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY at home			11. BIRTHPLACE (City and State or Foreign Country) Tennessee			12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Thomas Adamaon		13b. MOTHER'S MAIDEN NAME Margaret Atherton		14. NAME OF HUSBAND OR WIFE William Yankausky	
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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 Wm C. Yankausky, Collinsville,		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinoma of Colon extending to all bowel.</i>		DUPLICATE TO (b)					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION April 1952		19b. MAJOR FINDINGS OF OPERATION Carcinoma of bowel.				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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 153X	
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22. I hereby certify that I attended the deceased from Aug. 22, 1952, to Nov. 10, 1952, that I last saw the deceased alive on Nov. 10, 1952, and that death occurred at 9:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE Dr. Wayne M. Weaver		(Degree or title)		23b. ADDRESS 5437A Southwest Ave.		23c. DATE SIGNED 11/12/52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 11-11-52		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Collinsville, Ill.	
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DATE REC'D BY LOCAL REG. NOV 12 1952		REGISTRAR'S SIGNATURE J. C. Smith		25. FUNERAL DIRECTOR'S SIGNATURE Schroepfel, Collinsville, Ill.		ADDRESS	
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m 25. (Licensed Embalmer's Statement on Reverse Side)

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

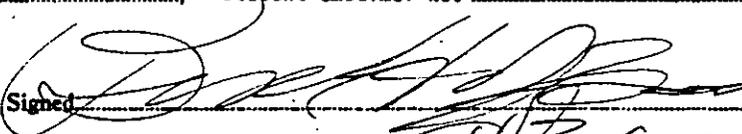
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

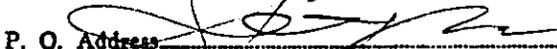
Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed 

Licensed Embalmer No. 

P. O. Address 

**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.