

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

13775

3649

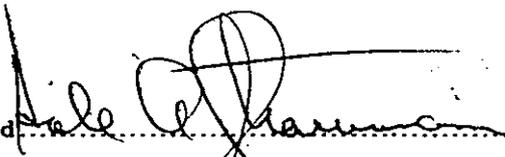
BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. ....		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>DePaul Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>14 4986 Oleatha Ave.</u> <u>2149</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>ADELE</u> b. (Middle) <u>B.</u> c. (Last) <u>McMAHON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 21 1954</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 14, 1905</u>		
9. AGE (In years last birthday) <u>49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk &amp; Secretary-Hyde Heating Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>Jacob Honig</u>		13b. MOTHER'S MAIDEN NAME <u>Beatrice Labadie</u>		14. NAME OF HUSBAND OR WIFE <u>Late Dennis McMahon</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Shirley Rouff 2733 Arlington Ave.</u>				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomatosis</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Carcinoma of ovaries</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>16 mos.</u>	
19a. DATE OF OPERATION <u>1/10/53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma ovaries</u>				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) <u>175X</u>				
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? _____				
22. I hereby certify that I attended the deceased from <u>Jan 5, 1953</u> , to <u>Apr 21, 1954</u> , that I last saw the deceased alive on <u>Apr 21, 1954</u> , and that death occurred at <u>2:30P</u> m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>John J. Shaner M.D.</u>				23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>4-22-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Apr. 24, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>		
DATE REC'D BY LOCAL REG. <u>APR 22 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl.</u>				

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.....  
Signature of Student Embalmer

Signed  .....  
Licensed Embalmer No. 453  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.