

**STANDARD CERTIFICATE OF DEATH**

25553

State File No. ....

No. 300  
10-48

FILED AUG 2 - 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 1713

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Maries</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Clayton</b> |  | c. CITY OR TOWN <b>Belle</b>   | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <b>1 mo.</b>  |  | e. STREET ADDRESS (If rural, give location) <b>0630</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>                    |  |  |  |

|  |  |                               |            |   |  |                                      |  |  |   |  |                        |   |                       |  |  |
|--|--|-------------------------------|------------|---|--|--------------------------------------|--|--|---|--|------------------------|---|-----------------------|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) <b>Charles</b>  |  |                               | a. (First) |   |  | b. (Middle) <b>McDaniel</b>          |  |  | c. (Last)                                 |  |                        | 4. DATE OF DEATH<br>(Month) (Day) (Year) <b>7-14-54</b> |                       |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b> |            | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b> |  | 8. DATE OF BIRTH <b>Feb. 1, 1867</b> |  |  | 9. AGE (In years last birthday) <b>87</b> |  | IF UNDER 1 YEAR Months |   | IF UNDER 4 HRS. Hours |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman-Retired</b> |  |                               |            | 10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Department</b>            |  |                                      |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Belle, Mo.</b> |   |  |                        | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                |                       |  |  |

|   |  |  |  |  |  |   |  |  |                                  |  |  |
|---|--|--|--|--|--|---|--|--|----------------------------------|--|--|
| 13a. FATHER'S NAME <b>Martin McDaniel</b>                                   |  |  | 13b. MOTHER'S MAIDEN NAME <b>Unknown</b> |  |  | 14. NAME OF HUSBAND OR WIFE <b>Alice McDaniel</b>       |  |  |                                  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> |  |  | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |  |  | 17. INFORMANT'S SIGNATURE OR NAME <b>Dorothy Benzen</b> |  |  | ADDRESS <b>10221 Unicorn Dr.</b> |  |  |

|   |  |   |  |  |  |  |  |                                  |  |
|---|--|---|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)   |  | MEDICAL CERTIFICATION   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| <p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p> |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Lung &amp; metastases.</b>   |  |  |  |  |  | <b>1 yr.</b>                     |  |
|   |  | ANTECEDENT CAUSES   |  |  |  |  |  |                                  |  |
|   |  | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last:<br>DUE TO (b) _____<br>DUE TO (c) _____    |  |  |  |  |  |                                  |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS  |  |  |  |  |  |                                  |  |
|   |  | Conditions contributing to the death but not related to the disease or condition causing death. <b>Arterio sclerosis-generalized - yrs.</b> |  |  |  |  |  |                                  |  |

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION                               |  | 19b. MAJOR FINDINGS OF OPERATION   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (m.) |  | 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 6-11, 1954, to 7-14, 1954, that I last saw the deceased alive on 7-14, 1954 and that death occurred at 4:30 p.m., from the causes and on the date stated above.

|   |  |                          |                                      |  |  |   |  |  |
|---|--|--------------------------|--------------------------------------|--|--|---|--|--|
| 23a. SIGNATURE <b>Halva S. Hoppe MD</b> (Degree or title) |  |                          | 23b. ADDRESS <b>601 S. Brentwood</b> |  |  | 23c. DATE SIGNED <b>7-15-54</b>               |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  |  | 24b. DATE <b>7-15-54</b> |                                      | 24c. NAME OF CEMETERY OR CREMATORY <b>Liberty, Mo.</b> |  | 24d. LOCATION (City, town, or county) (State) |  |  |

|   |  |   |  |   |  |                                      |  |
|---|--|---|--|---|--|--------------------------------------|--|
| DATE REC'D BY LOCAL REG. <b>7/16/54</b> |  | REGISTRAR'S SIGNATURE <b>Herbert K. ...</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> |  | ADDRESS <b>4700 Washington Blvd.</b> |  |
|---|--|---|--|---|--|--------------------------------------|--|

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 *John S. Lesne* .....  
Licensed Embalmer No. 419

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.