

FILED JAN 24 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 254  
Registrar's No. 63

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph		c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) most of life		e. STREET ADDRESS (If rural, give location) 2915 Douglas St. 01170	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2915 Douglas St.			

3. NAME OF DECEASED (Type or Print) Alice Fern Lyman			4. DATE OF DEATH (Month) (Day) (Year) January 15, 1955		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH August 6, 1908	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME George Shaffer	13b. MOTHER'S MAIDEN NAME Pearl E. Myers	14. NAME OF HUSBAND OR WIFE Charles N.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Charles Lyman, 2915 Douglas St. Joseph, Mo.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinomatous, generalized</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Carcinoma of ovary.</i> DUE TO (c)		1 year.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>175 X</i>			

19a. DATE OF OPERATION 17 June '54	19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of ovary, generalized metastasis</i>	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?
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22. I hereby certify that I attended the deceased from 16 June, 1954, to 14 Jan, 1955, that I last saw the deceased alive on 14 Jan, 1955; and that death occurred at 11:10a m., from the causes and on the date stated above.

23a. SIGNATURE <i>Wilbur C. McDonald, M.D.</i>	(Degree or title)	23b. ADDRESS <i>301 N. 8th St.</i>	23c. DATE SIGNED <i>18 Jan 55</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 1/17/1955	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG. Jan 21, 1955	REGISTRAR'S SIGNATURE <i>Kathleen M. Allison</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter S. Bauman - St. Joseph, Mo.</i>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 24 1957

Dr. Mc ...

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 *James B. Hawkins*

Licensed Embalmer No. 453

P. O. Address 319 So 10th St

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.