

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028203

STATE FILE NUMBER

FILED AUG 18 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 347

S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sedalia</u> <u>0804</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Univ. Med. Center</u>		Length of stay in 1b <u>40 days</u>	d. STREET ADDRESS (If outside, give location) <u>916 W. 6th Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Shane</u> Last <u>McFadden</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>11</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/15</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>	11. BIRTHPLACE (City and state or country) <u>Sedalia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America, U.S.</u>
13a. FATHER'S NAME <u>Michael T. Shane</u>		13b. MOTHER'S MAIDEN NAME <u>Josephine Terrill</u>		14. NAME OF HUSBAND OR WIFE <u>Victor A. McFadden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>no</u> or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>HOSPITAL RECORDS, Columbia, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of Rt. lung, recurrent</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____		DUE TO (c) _____		163X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>7 July '58</u> to <u>11 Aug '58</u> and last saw him alive on <u>1 Aug '58</u> Death occurred at <u>10:00 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>William H. Wade, M.D.</u>			22b. ADDRESS <u>h. of Mo. Hospital, Columbia</u>		22c. DATE SIGNED <u>8/11/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-11-1958</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>	
24. FUNERAL DIRECTOR <u>Parsons Funeral Service</u>		ADDRESS <u>Columbia, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 11 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>	

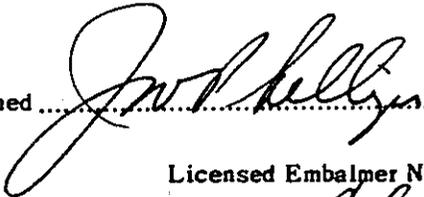
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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. 4887 .....

P. O. Address Columbia, Mo. ....

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.