

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045551  
STATE FILE NUMBER  
12210

FILED JAN 5 1959 Registration District No. 318 Primary Registration District No. 1003 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 <u>JEFF.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>DESOTO</u> 0502 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LUTHERAN HOSP.</u> Length of stay in lb <u>22 DA.</u>		d. STREET ADDRESS (If outside, give location) <u>RT. #3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>THEO.</u> Last <u>DANBACK</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>16</u> Year <u>1958</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>AUG 19, 1898</u>		9. AGE (In years last birthday) <u>60</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (City and state or country) <u>BISMARCK Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN DANBACK</u>			14. MOTHER'S MAIDEN NAME <u>MARTHA MILLER</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. <u>490-14-4347</u>		17. INFORMANT Address <u>BERTHA DANBACK Desoto Mo. RT. #3</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>Bronchiogenic Carcinoma &amp; Invasion of Esophagus.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>162.1</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral lower lobe pneumonia - bilateral; Metastases to Adrenal Glands.</u>		

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 _____ Month, Day, Year _____ a. m. _____ p. m. _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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>11/22/58</u> to <u>12/16/58</u> and last saw <sup>her</sup> <u>him</u> alive on <u>12/13/58</u> Death occurred at <u>10:15</u> AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles B. Obermeyer, M.D.</u>		22b. ADDRESS <u>4401 Hampton St. Louis Mo</u>	22c. DATE SIGNED <u>12/16/58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC. 19 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN PARK</u>	23d. LOCATION (City, town, or county) (State) <u>Desoto Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>P. B. DIETRICH Desoto Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 18 58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56

Health, Welfare Public Service  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All 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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was examined by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Donald B. Deady*.....

Licensed Embalmer No. *419*

P. O. Address *Seabrook*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.