

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006769

STATE FILE NUMBER

FILED FEB 24 1959

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 46

300  
-57 4

1. PLACE OF DEATH a. COUNTY <b>ST. CHARLES</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>ST. CHARLES</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis 2269</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>COLONIAL NURSING HOME</b>		Length of stay in 1b <b>4 mos</b>	d. STREET ADDRESS (If outside, give location) <b>2337 MAIDEN LANE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LORA</b> Middle <b>R</b> Last <b>McMAHAN</b>			4. DATE OF DEATH Month <b>2</b> Day <b>13</b> Year <b>59</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-1-1885</b>	9. AGE (In years last birthday) <b>73</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FORELADY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHOE FACTORY</b>	11. BIRTHPLACE (City and state or country) <b>ST. FRANCIS CO, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>SAMUEL BAKER</b>		13b. MOTHER'S MAIDEN NAME <b>WINIFRED MITCHELL</b>		14. NAME OF HUSBAND OR WIFE <b>CLARENCE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>497-18-2748</b>	17. INFORMANT Address <b>St. Charles, Mo</b> <b>CALLIE LEIGH, 724 NATHAN</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, generalized.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Primary, right breast</b>					<b>2 1/2 years</b>
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1705</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>1705</b>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <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 <b>October 28, 1958</b> to <b>Feb. 13, 1959</b> and last saw her alive on <b>Feb. 13, 1959</b> Death occurred at <b>5:15 p.</b> m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Don Z. Randall, M.D.</b>			22b. ADDRESS <b>207 N. 5th St. Charles, Mo.</b>		22c. DATE SIGNED <b>Feb 14, 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Removal</b>	<b>2-16-59</b>	<b>LOCAL</b>		<b>Roxie, Mo.</b>	
24. FUNERAL DIRECTOR <b>ALBERT H. HOPPE, 4700 WASHINGTON</b>			25. DATE RECD. BY LOCAL REG. <b>FEB 15-59</b>	26. REGISTRAR'S SIGNATURE <b>Marcella Wilson</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Elmer R. Cadwell

Licensed Embalmer No. 4077

P. O. Address St. Louis

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.