

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008467

STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 354

300
1-57 1

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, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1104 Ellsworth		Length of stay in lb 39 years	d. STREET ADDRESS (If outside, give location) 1104 Ellsworth		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last SYLVIA PEARL DANNER			4. DATE OF DEATH Month Day Year April 5, 1959		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1899		9. AGE (In years last birthday) 60 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) Employee		10b. KIND OF BUSINESS OR INDUSTRY Getchell Laundry		11. BIRTHPLACE (City and state or country) Ridgeway, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME William F. Smith		13b. MOTHER'S MAIDEN NAME Elizabeth Wiley	
14. NAME OF HUSBAND OR WIFE William H. Danner		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. 491-10-4964	
17. INFORMANT William Danner		Address 1104 Ellsworth, St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis					INTERVAL BETWEEN ONSET AND DEATH Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Bronchogenic Carcinoma					Unk.
DUE TO (c) _____					
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 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.) 1621		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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 11/5/58 , to 4/5/59 and last saw her/him alive on 4/4/59 Death occurred at 12:00 noon m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) S.E. Meloney M.D.		22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.		22c. DATE SIGNED 4/6/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4/8/1959		23c. NAME OF CEMETERY OR CREMATORY Asiland Cenetry	
23d. LOCATION (City, town, or county) (State) St. Joseph Mo.					
24. FUNERAL DIRECTOR Heaton-Bowman		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. April 8, 1959	
26. REGISTRAR'S SIGNATURE Mr. Clark Goodell					

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.

DR. S. E. MELONEY
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

10-11-1922

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 *W. H. Sperry*

Licensed Embalmer No. *4535*

P. O. Address *St. Joseph, 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.