

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011788

STATE FILE NUMBER

FILED MAR 30 1959

Registration District No. 317

Primary Registration District No. 590

Registrar's No. 754

300
-57

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FLORISSANT</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FLORISSANT</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>12 MARQUETTE DR.</u>		Length of stay in 1b <u>2 yrs 7 mos</u>	d. STREET ADDRESS (If outside, give location) <u>12 MARQUETTE DR.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARK WILLIAM SHANER</u>			4. DATE OF DEATH Month Day Year <u>MARCH 19 1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 22, 1956</u>	9. AGE (In years last birthday) <u>2</u>	IF UNDER 1 YEAR Months Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>WILLIAM S. SHANER, JR.</u>		13b. MOTHER'S MAIDEN NAME <u>JEANNINE WALTER</u>		14. NAME OF HUSBAND OR WIFE	
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>NONE</u>		17. INFORMANT Address <u>WMS. SHANER, JR., FLORISSANT, 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>Asphyxiation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>convulsions</u> DUE TO (c) <u>congenital brain damage since birth</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u> <u>since birth</u>	
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.) <u>351X</u>			
20c. TIME OF INJURY Hour a.m. Month, Day, Year 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>5-21-57</u> , to <u>5-11-59</u> and last saw ^{her} him alive on <u>7-10-58</u> Death occurred at <u>11 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John C. Murphy M.D.</u> (Degree or title)		22b. ADDRESS <u>32-N Central</u>		22c. DATE SIGNED <u>3-21-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAR 23, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co., MO.</u>	
24. FUNERAL DIRECTOR <u>THE FLORISSANT MORTUARY, FLORISSANT, MO.</u>		ADDRESS <u>FLORISSANT, MO.</u>		25. DATE REC'D. BY LOCAL REG. <u>3-21-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Gene A. Seltchens*

Licensed Embalmer No. *4966*

P. O. Address *FLORISSA, N.J.*

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.