

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS DEC 23 1959

'59 0 45 9 0 8

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211474**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI				Length of stay in 1b		c. CITY OR TOWN University City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 7101 Pershing Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
MAUDE			M.			SCHAFFNER			DECEMBER 10 1959		
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-22-1888		9. AGE (last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Lincoln Co., Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME James Henry Eddens				13b. MOTHER'S MAIDEN NAME Margaret Palmer				14. NAME OF HUSBAND OR WIFE er Late Frederick Schaffn			
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. None		17. INFORMANT Mabel Coiro		Address 7101 Pershing Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS WITH HEPATIC METASTASES								INTERVAL BETWEEN ONSET AND DEATH 8 1/2 MONTHS			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								157L			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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.		Month, Day, Year									
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 NOV. 2, 1959 to DEC. 10, 1959 and last saw her DEC. 10, 1959				Death occurred at 1:35 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>C. D. Vanellia, M.D.</i> (Degree or title) M. D.				22b. ADDRESS BARNES HOSPITAL				22c. DATE SIGNED 12/10/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE Dec. 12, 1959		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Mausoleum		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.					
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway				25. DATE RECD. BY LOCAL REG. DEC 11 1959		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i> M. D.					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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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 R W Stovessand

Licensed Embalmer No. 4007

P. O. Address _____

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.