

No. 300
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See serial

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED APR 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14345

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 779

1. PLACE OF DEATH a. COUNTY St. Louis County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jennings	
c. LENGTH OF STAY (in this place) 10 days		d. STREET ADDRESS (If rural, give location) 2324 Glade	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis County Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) LUTHER	b. (Middle)	c. (Last) SMITH	4. DATE OF DEATH (Month) (Day) (Year) March 27, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan. 6, 1899	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months 2	IF UNDER 1 YEAR Days 21	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Evansville, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Smith	13b. MOTHER'S MAIDEN NAME Kate Fowler	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Records St. Louis County Hospital	ADDRESS Hospital
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured esophageal varix		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Lameness cirrhosis of the liver		
DUE TO (c) Anemia			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **March 14, 1949**, to **March 27, 1949**, that I last saw the deceased alive on **March 27, 1949**, and that death occurred at **8:45 pm.**, from the causes and on the date stated above.

23a. SIGNATURE Edmund R. Thiel (Degree or title) M.D.	23b. ADDRESS St. Louis County Hosp.	23c. DATE SIGNED 3/29/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/2/49	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis County
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DATE REC'D BY LOCAL REG. 3-31-49	REGISTRAR'S SIGNATURE Therese Linnig	25. FUNERAL DIRECTOR'S SIGNATURE Mark T. Larson	ADDRESS
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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
Student Embalmer

Signed

Robert M Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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 this body is not embalmed, fact should be so stated above.