

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6762  
1652

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE Missouri b. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (in this place)  
St. Louis

c. CITY (If outside corporate limits, write RURAL and give township)  
St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
1917 Delmar

d. STREET ADDRESS (If rural, give location)  
1917 Delmar Blvd

3. NAME OF DECEASED  
a. (First) LILLIAN b. (Middle) \_\_\_\_\_ c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year)  
Feb. 19, 1950

5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH June 4, 1994 9. AGE (in years last birthday) 55 10. MONTHS 8 11. DAYS 13 IF UNDER 1 YEAR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Domestic

10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (State or foreign country)  
Monroe La

12. CITIZEN OF WHAT COUNTRY?  
U. S. A

13a. FATHER'S NAME Sam Jackson 13b. MOTHER'S MAIDEN NAME Mary Lamb 14. NAME OF HUSBAND OR WIFE Arcear Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) \_\_\_\_\_

16. SOCIAL SECURITY NO. 493-20-5390

17. INFORMANT'S SIGNATURE OR NAME ADDRESS  
Dr. Lee Scruggs, 1917 Delmar Blvd

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Chronic Aortitis

INTERVAL BETWEEN ONSET AND DEATH \_\_\_\_\_

\* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

ANTECEDENT CAUSES  
DUE TO (b) Aortic Stenosis

DUE TO (c) Chronic Hepatitis

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.  
Chronic Interstitial

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION Nephritis 20. AUTOPSY? YES  NO

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)  
5810

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) \_\_\_\_\_ 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 1238 P.M., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) Patrick B Taylor M.D. 22b. ADDRESS 1300 Clark 22c. DATE SIGNED 2-20-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 2-23-1950 24c. NAME OF CEMETERY OR CREMATORY Washington Park 24d. LOCATION (City, town, or county) (State) St. Louis Mo

DATE REC'D BY LOCAL HEALTH DEPT. FEB 20 1950 REGISTRAR'S SIGNATURE B. L. Luster 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William Wood 3644 Finney Ave

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

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

*Louis V. Atkins*

Licensed Embalmer No. 2842

P. O. Address 3644 Finney

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.