

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11118

State File No. ....

#55174

BIRTH NO. ....

REG. DIST. NO. ....

318

PRIMARY REG. DIST. NO. ....

1003

Registrar's No. ....

2183

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) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 21 - 1351 N. Leffingwell					
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM		b. (Middle) H.		c. (Last) SMITH			
4. DATE OF DEATH Feb. 23, 1950		5. SEX male		6. COLOR OR RACE white			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH Oct. 31st, 1880		9. AGE (In years last birthday) 69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri			
13a. FATHER'S NAME Silas Smith		13b. MOTHER'S MAIDEN NAME Anna unknown		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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Margaret Kelly			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) 332X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/10/50 to 2/23/50, 1950, that I last saw the deceased alive on 2/23/50 at AURMANN, and that death occurred at 5:50 PM, from the causes and on the date stated above.							
23a. SIGNATURE E. Fauser M.D.		EDWARD LAURMANN (Degree or title)		23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 2/23/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3-8-50		24c. NAME OF CEMETERY OR CREMATORY CALVARY		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REG. MAR 7 1950		REGISTRAR'S SIGNATURE J. B. Jasater		25. FUNERAL DIRECTOR'S SIGNATURE Cullen Kelly		ADDRESS 4386 Lindell	

(Licensed Embalmer's Statement on Reverse Side)

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  
at College of Mortuary Science  
working under my personal supervision.

Student Embalmer No.....

Signed Ralph W. Hemmer

Signed.....  
Student Embalmer

Licensed Embalmer No. 3791

P. O. Address St. Louis, MO.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.