

FILED AUG 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28686**
6866

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) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION HOMER G. PHILLIPS HOSP.		d. STREET ADDRESS (If rural, give location) 2726th SHERIDAN	

3. NAME OF DECEASED (Type or Print) ELMIRA SMITH			4. DATE OF DEATH (Month) (Day) (Year) 8-6-1950			
5. SEX 3 FEMALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JAN. 6, 1895	9. AGE (In years last birthday) 75/45	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. 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) ALA.		12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME ?		13b. MOTHER'S MAIDEN NAME SMITH		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Irene Bankhead-2726th Sherman ADDRESS _____	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture neck of left femur ANTECEDENT CAUSES Arteriosclerosis Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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
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19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis MO MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 19-50 3:30 pm		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? fall 69020	

22. I hereby certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **9:25 AM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 8/9/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 7-12-50		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK cem.	
24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO		25. FUNERAL DIRECTOR'S SIGNATURE A.F. WALTON		ADDRESS 2707 STODDARD ST.	
DATE REC'D BY LOCAL REG. AUG 12 1950		REGISTRAR'S SIGNATURE [Signature]			

No. 300
10.48
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Emb Separate Cert filed

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.....

Licensed Embalmer No.....

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