

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39068

FILED DEC 1 1950

State File No.

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|--|--|--|--|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | | c. LENGTH OF STAY (In this place) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | | 2189 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u> | | | | d. STREET ADDRESS (If rural, give location) <u>3432 LaSalle</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Katie</u> | | a. (First) | | b. (Middle) | | c. (Last) <u>Smith</u> | |
| 4. DATE OF DEATH <u>Nov. 22 1950</u> | | (Month) | | (Day) | | (Year) | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> | | 8. DATE OF BIRTH <u>Dec. 3, 1900</u> | |
| 9. AGE (In years last birthday) <u>49</u> | | 10. MONTHS <u>11</u> | | 11. DAYS <u>19</u> | | 12. HOURS <u>19</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ma id</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) <u>Lake Providence, La</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Lula Jackson</u> | | 14. NAME OF HUSBAND OR WIFE _____ | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Gertrude Nickerson</u> | | ADDRESS <u>3432 LaSalle</u> | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Cervix with Metastasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Undetermined</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u> | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input checked="" 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) _____ | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>171X</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>7-29</u> , 19 <u>50</u> , to <u>11-22</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>11-22</u> , 19 <u>50</u> , and that death occurred at <u>4:58</u> p. m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>M. D. Smiley</u> (Degree or title) _____ | | | | 23b. ADDRESS <u>2601 N Whittier St.</u> | | 23c. DATE SIGNED <u>11-24-50</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>11-27-50</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>LeMay, Mo.</u> | |
| DATE REC'D BY LOCAL <u>NOV 24 1950</u> | | REGISTRAR'S SIGNATURE <u>J. B. Laster</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>E. B. France</u> | | ADDRESS <u>1221 N. Grand</u> | |

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *Lawrence Crossman*

Licensed Embalmer No. *4755*

P. O. Address *1321 N Grand*

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.