

MAY 19 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18567

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4268**

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 (If not in hospital or institution, give street address or location) DR. ROBERT T. HOSPITAL		d. STREET ADDRESS (If rural, give location) 1109 E. N. 23rd St	

3. NAME OF DECEASED (Type or Print) **RAYMOND SMITH**

a. (First) b. (Middle) c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) **MAY 4 1952**

5. SEX **M** 6. COLOR OR RACE **Col** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **SINGLE** 8. DATE OF BIRTH **OCT. 27 1926** 9. AGE (In years last birthday) Months Days **25 6 9**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **TIE CUTTER** 10b. KIND OF BUSINESS OR INDUSTRY **Boyd Necktie Co.** 11. BIRTHPLACE (State or foreign country) **ST. LOUIS MO** 12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME **LEON SMITH** 13b. MOTHER'S MAIDEN NAME **OLLIE MAE TAYLOR** 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 **OLLIE MAE SMITH** ADDRESS **1109 E. N. 23rd St**

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Acute Diffuse Peritonitis**

ANTECEDENT CAUSES **Cholelithiasis** DUE TO (b) **Perforated Gastric Ulcer**

DUE TO (c) **Ulcer**

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 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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? **5401**

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 **12:28 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE **Walter Perry Spurgeon** (Degree or title) 23b. ADDRESS **1300 Clay** 23c. DATE SIGNED **5/7/52**

24a. BURIAL, CREMATION, OR REMOVAL (Specify) 24b. DATE **May-9-52** 24c. NAME OF CEMETERY OR CREMATORY **Jefferson Burche** 24d. LOCATION (City, town, or county) (State) **St. Louis County**

DATE REC'D BY LOCAL REG. **MAY 7 1952** REGISTRAR'S SIGNATURE **J. Earl Smith, M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE **A.F. WALTON** ADDRESS **2707 STODDARD ST.**

50 (Licensed Embalmer's Statement on Reverse Side)

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

854
3
Main

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4524 Aldine

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.