

FILED OCT 15 1953

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **34089**
 Registrar's No. **8803**

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 34089		Registrar's No. 8803					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE St. Louis, Missouri b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri			c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				e. STREET ADDRESS (If rural, give location) 2-8 No Home									
3. NAME OF DECEASED (Type or Print) HERBERT			a. (First)		b. (Middle)		c. (Last) SMITH		4. DATE OF DEATH (Month) (Day) (Year) AUGUST 23, 1953				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Dec. 19, ?		9. AGE (In years last birthday) 46 78		# UNDER 1 YEAR Months Days		# UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Ohio			12. CITIZEN OF WHAT COUNTRY? _____				
13a. FATHER'S NAME ?				13b. MOTHER'S MAIDEN NAME ?				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 Hospital Record 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pseudomonas aeruginosa Septicemia ANTECEDENT CAUSES 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. congestive heart failure cerebral thrombosis								INTERVAL BETWEEN ONSET AND DEATH _____			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 053.3							
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? _____									
22. I hereby certify that I attended the deceased from 8-3-53 , 19____, to 8-23-53 19____, that I last saw the deceased alive on 8-23-53 , 19____, and that death occurred at 4:30P m., from the causes and on the date stated above.													
23a. SIGNATURE Robert B. Katens (Degree or title) M.D.				23b. ADDRESS 1515 Lafayette Avenue				23c. DATE SIGNED 8-24-53					
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE 9-30-53		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board			24d. LOCATION (City, town, or county) (State) St. Louis, Mo.						
DATE REC'D BY LOCAL REG. SEP 11 1953		REGISTRAR'S SIGNATURE J. Carl Smith				25. FUNERAL DIRECTOR'S SIGNATURE Kowland Mortuary Service		ADDRESS 4104 Manchester Ave.					

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

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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