

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41184**
11176
Registrar's No.

FILED DEC 4 - 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 OR TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis TOWN	
d. FULL NAME OF HOSPITAL OR INSTITUTION 920a Nth. Leonard Ave.		d. STREET ADDRESS (If rural, give location) 920a Nth. Leonard Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Fred	b. (Middle) Bell	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) 11 - 22 - 1953
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5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6 - 14 - 1897	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY City Rubbish	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Joe Smith	13b. MOTHER'S MAIDEN NAME Lillie Deemer	14. NAME OF HUSBAND OR WIFE Joanna Smith
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 497-011-457	17. INFORMANT'S SIGNATURE OR NAME Joanna Smith	ADDRESS 920a Nth. Leonard Ave.
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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		INTERVAL BETWEEN ONSET AND DEATH 2 mos
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Congenital Heart Failure		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) Chronic Bronchitis and Bronchiectasis		
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4222
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22. I hereby certify that I attended the deceased from **Aug 29, 1953**, to **Nov 22, 1953**, that I last saw the deceased alive on **Nov 21, 1953**, and that death occurred at _____ m. from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title) M. D.	23b. ADDRESS 3524 Franklin Ave.	23c. DATE SIGNED 11-24-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-28-1953	24c. NAME OF CEMETERY OR CREMATORY Washington Prk. Cem.	LOCATION (City, town, or county) (State) Berkley City, Missouri
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DATE REC'D BY LOCAL REG. NOV 25 1953	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS 3759 Finney Ave.
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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.

Student
Student Embalmer

Signed

Lester G. Johnson

Licensed Embalmer No. *4341*

P. O. Address *St. Louis Mo*

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.