

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3290**
Registrar's No. **0432**

FILED FEB 2 1954

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

1. PLACE OF DEATH
a. COUNTY **Mo.**

b. CITY (If outside corporate limits, write RURAL and give town) **St. Louis**
c. CITY OR TOWN **St. Louis**
d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **4932 West Florissant Ave**
e. STREET ADDRESS (If rural, give location) **4932 West Florissant Ave. 0**

3. NAME OF DECEASED
a. (First) **Leila** b. (Middle) **R.** c. (Last) **Smith**
4. DATE OF DEATH (Month) (Day) (Year) **Jan. 14, 1954**

5. SEX **F.** 6. COLOR OR RACE **W.** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed** 8. DATE OF BIRTH **Oct. 28, 1886** 9. AGE (In years last birthday) **67** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **At Home** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) **St. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13a. FATHER'S NAME **Leland Powell** 13b. MOTHER'S MAIDEN NAME **Rose Stinson** 14. NAME OF HUSBAND OR WIFE **William L. Smith**

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. **None** 17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Mrs. Paul M. Gerwitz 30 Middlesex Dr.**

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, asthma, etc. It means the disease, injury, or complication which caused death.
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Coronary Occlusion** INTERVAL BETWEEN ONSET AND DEATH **Immediate**
ANTECEDENT CAUSES DUE TO (b) **Arteriosclerosis** **3 yrs**
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS **Diabetes** **8 yrs**
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **none** 19b. MAJOR FINDINGS OF OPERATION **none** 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) **none** 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **none** 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) **none** 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? **none** **4201**

22. I hereby certify that I attended the deceased from **7-1, 1950**, to **1-14, 1954**, that I last saw the deceased alive on **1-14, 1954**, and that death occurred at **3:20 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **M. Blachle M.D.** 23b. ADDRESS **7124 Natural Bridge** 23c. DATE SIGNED **1-15-54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **1-18-54** 24c. NAME OF CEMETERY OR CREMATORY **Calvary Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis, Mo.**

DATE REC'D BY LOCAL REG. **JAN 15 1954** REGISTRAR'S SIGNATURE **J. Carl Smith, M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Arthur J. Donnelly 3840 Lindell**

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 *me*....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *[Signature]*.....
Licensed Embalmer No. 46.....
P. O. Address *[Signature]*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.