

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3292**
Registrar's No. **0409**

FILED FEB 2 1954

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

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

1. PLACE OF DEATH a. COUNTY <u>0</u>		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 town) <u>Saint Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Saint Louis</u> <u>2109</u>	
c. LENGTH OF STAY (In this place) <u>Life</u>		d. STREET ADDRESS (If rural, give location) <u>4560a Lexington Avenue, 15,</u> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Old Faith Hospital</u>			
3. NAME OF DECEASED a. (First) <u>MINNIE</u> (Type or Print)		b. (Middle) <u>L.</u>	
		c. (Last) <u>SMITH</u>	
		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 13th, 1954</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 14th, 1877</u>
9. AGE (In years last birthday) <u>76</u>		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) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Saint Louis, Missouri</u> <u>0</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Johanna Wolfers</u>	
		14. NAME OF HUSBAND OR WIFE <u>George E. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Esther Smith, 4560a Lexington Ave., 15</u>	
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) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Renalosis 1 yr</u> DUE TO (c) <u>Chr. Arthritis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Rt. Hemiplegia</u>	
		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>1 yr</u> <u>24 hrs.</u>	
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) <u>St. Louis</u> <u>Missouri</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR? _____ <u>442x</u>	
22. I hereby certify that I attended the deceased from <u>1/12/54</u> , 19 <u>54</u> , to <u>1/13/54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>1/13/54</u> , 19 <u>54</u> , and that death occurred at <u>7:30P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Anthony J. Vitale M.D.</u>		23b. ADDRESS <u>38.61 St. Louis Ave</u>	
		23c. DATE SIGNED <u>1/14/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1/18/54</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>JAN 15 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MO</u>	
		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd. FUNERAL HOME, INC., St. Louis, 15, Missouri</u>	

File in City

10:00AM to 5:00 PM Daily

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

John A. Minner

Licensed Embalmer No. *4186*

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.