

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

10708

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>590</u>		Registrar's No. <u>659</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY OR TOWN <u>Brentwood, Missouri</u>		c. LENGTH OF STAY (in this place) <u>2 YEARS</u>		c. CITY OR TOWN <u>Webster Groves</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>8950 Manchester Road</u>				e. STREET ADDRESS (If rural, give location) <u>643 Fairview</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mattie</u> b. (Middle) <u>Knowles</u> c. (Last) <u>Smith</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 15 1954</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov 8 1886</u>	
9. AGE (in years last birthday) <u>67</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Rhode, Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Roscoe Knowles</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Perry</u>		14. NAME OF HUSBAND OR WIFE <u>John L. Smith, dec'd</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>Nil</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Craig Smith, 643 Fairview</u> 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, asthma, 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 DUE TO (b) <u>Hypertensive cardio vascular disease</u> , 2 yrs. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</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) _____			
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 <u>May 8, 1952</u> , to <u>March 2, 1954</u> , that I last saw the deceased alive on <u>March 2, 1954</u> , and that death occurred at <u>3:05 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>Kirkwood 22, Missouri</u>		23c. DATE SIGNED <u>3-15-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3-16-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Wakefield, Rhode Island</u>	
DATE REC'D BY LOCAL REG. <u>3/16/54</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe, 4700 Washington Blvd</u> ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

Student.....
Signature of Student Embalmer

Signed..... *Paul A. Wachtel*

Licensed Embalmer No. *478*

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.