

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14120**

BIRTH NO. 26873-54 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3122**

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 township) St Louis		c. CITY OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		e. STREET ADDRESS (If rural, give location) 3219 La Salle	
3. NAME OF DECEASED (Type or Print) a. (First) Smalley		b. (Middle)	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) March 30 1954	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ---	8. DATE OF BIRTH March 29 1954
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours Min. 2 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri		12. CITIZEN OF WHAT COUNTRY? ---	
13a. FATHER'S NAME James Smalley		13b. MOTHER'S MAIDEN NAME Reaster Stewart	
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 Reaster Smalley	
ADDRESS 3219 La Salle St Louis		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION, I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Polycystic Kidney Disease ANTECEDENT CAUSES ? Fibrous band constricting posterior urethra 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 757.1	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 March 29, 1954 , to March 30, 1954 , that I last saw the deceased alive on March 30, 1954 , and that death occurred at 5:15 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) E. H. Krause M.D.		23b. ADDRESS St. Louis Maternity Hosp 4/2/54	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 4-30-54		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland	
DATE REC'D BY LOCAL REG. APR 7 1954		ADDRESS 4104 Hancock	

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.....

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.