

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 8 1955

State File No. 28168

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7431

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) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 38 Years		c. CITY OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 1418 Hills Terrace		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) a. (First) Estelle		b. (Middle) Fredia		c. (Last) Smith			
4. DATE OF DEATH (Month) (Day) (Year) 8 21 55		5. SEX Female		6. COLOR OR RACE COL.			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 3/19/1905		9. AGE (In years last birthday) IF UNDER 1 YEAR Days IF UNDER 12 HRS. Hours Min. 50 5 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Domestics		11. BIRTHPLACE (City and State or Foreign Country) / Bellville Illinois			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Andrew Lyke		13b. MOTHER'S MAIDEN NAME Mary Randle			
14. NAME OF HUSBAND OR WIFE Ted Bruce Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 496-22-9746			
17. INFORMANT'S SIGNATURE OR NAME Ted B. Smith		ADDRESS 1418, Hill Terrace					
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) Glomerulonephritis, chronic. Hypertensive cardio-vascular disease. ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ 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. Cardiac insufficiency. Uremia.				INTERVAL BETWEEN ONSET AND DEATH Undt.	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 592 X			
22. I hereby certify that I attended the deceased from 8-10-1955, to 8-21-1955, that I last saw the deceased alive on 8-21-1955, and that death occurred at 9:50 p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Chas. B. Williams M.D.		23b. ADDRESS 2601 N. Whittier Street		23c. DATE SIGNED 8-22-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8/27/55		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery			
24d. LOCATION (City, town, or county) (State) St. Louis Missouri		DATE REC'D BY LOCAL REG. AUG 24 1955		REGISTRAR'S SIGNATURE Carl Smith			
25. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Houston		ADDRESS 2616, North Garrison Ave.					

(Licensed Embalmer's Statement on Reverse Side)

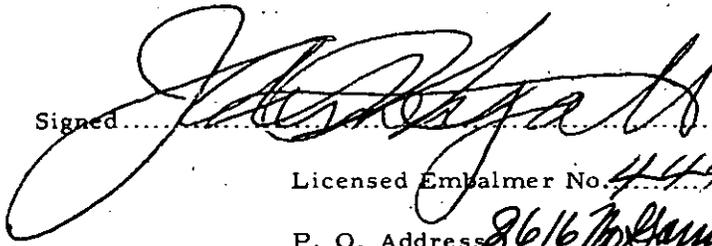
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....



Licensed Embalmer No. 444

P. O. Address 2616 Toxham

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.