

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38908

State File No.

318

PRIMARY REG. DIST. NO. 1003 Registrar's No. 10517

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10517	
1. PLACE OF DEATH a. COUNTY _____				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 township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Baptist Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>5627 Cabanne</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BEN</u> b. (Middle) <u>(NMI)</u> c. (Last) <u>SMUCKLER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 30, 1955</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Jan. 8, 1897</u>	
9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hour _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Grocery</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Max Smuckler</u>			13b. MOTHER'S MAIDEN NAME <u>Rose Cohe n</u>		14. NAME OF HUSBAND OR WIFE <u>Rose T. Smuckler</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>488-03-1573</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Rose Smuckler 5627 Cabanne</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of Bladder</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.					INTERVAL BETWEEN ONSET AND DEATH <u>3.5 years</u>
19a. DATE OF OPERATION <u>Sept 52</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cancer of Bladder</u>				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>1814</u>			
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>Sept</u> , 19 <u>52</u> , to <u>Nov. 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/30/55</u> , and that death occurred at <u>12 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Alan McFee M.D.</u>				23b. ADDRESS <u>457 N. Kings Highway</u>		23c. DATE SIGNED <u>12/21/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>12/2/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>		24d. LOCATION (City, town, or county) (State) <u>Univ. City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>DEC. 1 1955</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Berger Memorial 4715 McPherson</u>			

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

(Licensed Embalmer's Statement on Reverse Side)

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..... *Samuel J. DeLia*

Licensed Embalmer No. 898

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.