

FILED APR 12 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11444

State File No.

318

REG. DIST. NO. 1003 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3195

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3195			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN HOOD Maplewood		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 St. John's Hospital				e. STREET ADDRESS (If rural, give location) 2647 Lyle Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) ALBERT			b. (Middle) _____		c. (Last) SMITH		4. DATE OF DEATH (Month) (Day) (Year) March. 28th, 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sep. 9, 1873		9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Postal Clerk-U.S. Post Office		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Verona, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME August Smith		13b. MOTHER'S MAIDEN NAME Emily Jonas		14. NAME OF HUSBAND OR WIFE Dora T. Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dora T. Smith 2647 Lyle Ave.					
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-Vascular Accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral anterior choroid DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 33/4				INTERVAL BETWEEN ONSET AND DEATH 3 da	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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) _____					
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 25, 1956, to March 29, 1956, that I last saw the deceased alive on March 27, 1956, and that death occurred at 1:05 A.M., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <i>Forster A. Dell</i>				23b. ADDRESS 7346 a Manchester ave. Maplewood 17, Mo.		23c. DATE SIGNED 3-29-56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail)		24b. DATE 3-29-1956		24c. NAME OF CEMETERY OR CREMATORY Spring River Cemetery		24d. LOCATION (City, town, or county) Verona, Mo. (State) _____			
DATE REC'D BY LOCAL REG. MAR 29 1956		REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.					

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

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 *William B. White*.....

Licensed Embalmer No. *4*

P. O. Address *422 8th King*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.