

Health, Welfare, Public Service

300 1-56

ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
D. R. Hoppe, M.D.

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29149

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6590**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> <b>2089</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>344a Blase Ave.</b>		Length of stay in lb <b>9 mo.</b>	d. STREET ADDRESS <b>344a Blase Ave.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Gertrude</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 9, 1882</b>	9. AGE (In years last birthday) <b>74</b>
IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hour	IF UNDER 24 HRS. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Vulcan, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Lee Kelly</b>			14. MOTHER'S MAIDEN NAME <b>Frances Knight</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Leamon Smith, 127 Coburg Dr.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>Previous cerebral hemorrhage &amp; Hemiplegia</b> DUE TO (b) <b>Arteriosclerosis</b> <b>Old fracture hip &amp; dementia (senile)</b> DUE TO (c) <b>Arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7-9-56</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.			<b>331 x F</b>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>7-9-56</b>	20f. CITY, TOWN, OR LOCATION <b>Minimum, Mo.</b>		STATE
21. <b>attended the deceased from 7-9-56 and 7-13-56</b> and last saw <b>her</b> alive on <b>7-9-56</b> Death occurred at <b>11:05a</b> m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Wm. A. Knight M.D.</b>			22b. ADDRESS <b>8201 North Broadway</b>		22c. DATE SIGNED <b>7-13-56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7-13-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>Minimum, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>JUL 14 1956</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	

T.P.

365 37 100

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ..... Student Embalmer No. ....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *J W Bentley*.....  
Licensed Embalmer No. *365*

P. O. Address *St Louis*

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

*h*