

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29159

State File No.

6290

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3915 Bowen St.		STREET ADDRESS (If rural, give location) 3915 Bowen St.		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) NETTIE		b. (Middle) DEAL		c. (Last) SMITH		4. DATE OF DEATH (Month) (Day) (Year) July 3 1956	
-------------------------------------	--	--------------------------	--	-------------------------	--	------------------------	--	--	--

5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Aug. 29, 1870		9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
----------------------	--	-------------------------------	--	---	--	---------------------------------------	--	---	--	-----------------------------	--	-----------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) Charleston, Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
--	--	--	-----------------------------------	--	--	---	--	--	--	--	--

13a. FATHER'S NAME Joseph T. Adams			13b. MOTHER'S MAIDEN NAME Florence Maggard			14. NAME OF HUSBAND OR WIFE Late Woodbury W. Smith		
---	--	--	---	--	--	---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carrie Deal Kemper 3915 Bowen St.			
---	--	-------------------------------------	--	--	--	--	--

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						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Chronic sclerotic myocarditis Chronic nephrosclerosis						7 wk.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4201						Years	

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?	
--	--	--	--	----------------------------	--

22. I hereby certify that I attended the deceased from **July 1947** to **July 3, 1956**, that I last saw the deceased alive on **7/3/56**, and that death occurred at **1:10 P.M.** from the causes and on the date stated above.

23a. SIGNATURE C. L. Ruabert M.D.		(Degree or title)		23b. ADDRESS 5203 Chippewa		23c. DATE SIGNED 7/3/56	
--	--	-------------------	--	-----------------------------------	--	--------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE July 5, 1956		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
--	--	-------------------------------	--	--	--	--	--

DATE REC'D BY LOCAL REG. JUL 5 1956		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.			
--	--	--	--	---	--	--	--

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 *William B. White*.....

Licensed Embalmer No. *4281*

P. O. Address *4281*

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.