

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

34159

STATE FILE NUMBER

8174

FILED SEP 17 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

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>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>New Faith Hospital</b>			Length of stay in lb <b>5 days</b>		d. STREET ADDRESS <b>4223 Botannical</b>	
3. NAME OF DECEASED (Type or print) First <b>Nola</b> Middle <b>Chestine</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 26, 1905</b>	9. AGE (In years last birthday) <b>51</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Woman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Dry Goods</b>	11. BIRTHPLACE (City and state or country) <b>Fayette County, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Alvertice Pilcher</b>			13b. MOTHER'S MAIDEN NAME <b>Cora Waddelow</b>		14. NAME OF HUSBAND OR WIFE <b>Elbert Smith</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>unk</b>		17. INFORMANT Address <b>Verla Smith, 4223 Botannical, St. Louis, Mo.</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>Metastatic adenocarcinoma 3 yrs of lungs, mediastinal lymph nodes + skull, primary - colon</b>						INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>of lungs, mediastinal lymph nodes + skull, primary - colon</b>						
DUE TO (c) <b>of lungs, mediastinal lymph nodes + skull, primary - colon</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT: 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.) <b>153x</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>June 1957</b> to <b>8/30/57</b> and last saw her alive on <b>8/29/57</b> Death occurred at <b>7:50 AM 8/30/57</b> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>Marlin Bergmann MD</b>				22b. ADDRESS <b>4500 Olive</b>		22c. DATE SIGNED <b>8/30/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8-30-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Liberty</b>		23d. LOCATION (City, town, or county) (State) <b>Bond County, Illinois</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 3 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b> <b>MSB</b>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Elton H. Penelux .....

Licensed Embalmer No. 4283 .....

P. O. Address St. Louis, Mo. .....

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.