

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

34355
STATE FILE NUMBER
8970
Registrar's No.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		
5. SEX		6. COLOR OR RACE		
7. MARRIED NEVER MARRIED WIDOWED DIVORCED		8. DATE OF BIRTH		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): <u>420.1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>1 hr</u> <u>Yes</u>
20a. ACCIDENT SUICIDE HOMICIDE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY		20d. INJURY OCCURRED WHILE AT WORK		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		
21. I attended the deceased from <u>Jan 1957</u> to <u>Sept 24, 1957</u> and last saw her alive on <u>Sept 24, 1957</u> Death occurred at <u>1030 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE		22b. ADDRESS		
22c. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.		
26. REGISTRAR'S SIGNATURE				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

116 St. Louis Ave, E. St. Louis, Ill. (Licensed Embalmer's Statement on Reverse Side)

J. Earl Smith, M.D.
3 P.

APR 4 1958

APR 8 1958

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 *Lawrence J. Mey* Student Embalmer No.
No Embalmer

Licensed Embalmer No.
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.