

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10332**

5. 300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ST. LOUIS CITY HOSP INSTITUTION		Length of stay in lb #1.	d. STREET (If outside, give location) ADDRESS 534 N. Vandeventer		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FRED Middle FAY Last SMITH			4. DATE OF DEATH Month OCT. Day 31, Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15 1875	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bill Poster		10b. KIND OF BUSINESS OR INDUSTRY Advertising Co	11. BIRTHPLACE (City and state or country) New London Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Fred Smith		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Bertha Wilcox Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.I		16. SOCIAL SECURITY NO. 494-10-3295	17. INFORMANT Address Austin F. Shirk Housesprings Mo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) arteriosclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0					INTERVAL BETWEEN ONSET AND DEATH
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.					
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 10/29/57 to 10/31/57 and last saw her alive on 10/31/57 Death occurred at 3:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Dr. H. Seifert M.D.			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 11/1/57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Nov 2 1957	23c. NAME OF CEMETERY OR CREMATORY Nat'l Cemetery J.B.		23d. LOCATION (City, town, or county) (State) St. Louis Mo.
24. FUNERAL DIRECTOR ADDRESS Wm. J. Morrell 3710 N. Grand Blv			25. DATE RECD. BY LOCAL REG. NOV 2 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith MD mjb	

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.

