

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38176
STATE FILE NUMBER
10308

FILED NOV 8 1957

318

1003

Registration District No. Primary Registration District No. Registrar No.

Health,
Welfare
Public
Services

300
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>ST. Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Baptist Hosp</u> | | | Length of stay in 1b <u>16</u> | d. STREET (If outside, give location) ADDRESS <u>4604 Maffitt</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ollie</u> Middle <u>Tyler</u> Last <u>Smith</u> | | | 4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>57</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-23-1895</u> | 9. AGE (In years last birthday) <u>61</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (City and state or country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> |
| 13. FATHER'S NAME <u>Luden Tyler</u> | | | 14. MOTHER'S MAIDEN NAME <u>Not Known</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT Address <u>Joseph R. Smith 4604 Maffitt.</u> | | |
| 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>Cardiac Decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardia-</u> DUE TO (c) <u>vascular disease</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>10 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of fundus of uterus (Gr. I)</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>443X #</u> | | | |
| 20c. TIME OF INJURY Hour <u>8 A</u> Month <u>Nov</u> Day <u>30</u> Year <u>1957</u> | | | | | |
| 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.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>Nov. 30</u> to <u>Oct 31, 1957</u> and last saw her <u>him</u> alive on <u>Oct 30, 1957</u> Death occurred at <u>8 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Name or title) <u>Richard G. Jones MD</u> | | | 22b. ADDRESS <u>3720 Washington</u> | | 22c. DATE SIGNED <u>11-1-57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11-4-57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine</u> | | 23d. LOCATION (City, town, or county) (State) <u>ST. Louis Mo</u> | |
| 24. FUNERAL DIRECTOR <u>A. Nixon</u> | | ADDRESS <u>2707 N. Grand</u> | | 25. DATE RECD. BY LOCAL REG. <u>NOV 1 '57</u> | 26. REGISTRAR'S SIGNATURE <u>Earl Smith MD</u> <u>m&B</u> |

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 *Gustav W. Suter*

Licensed Embalmer No. *43*

P. O. Address *St. Louis*

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.