

pt. Health,
, & Welfare
S. Public
lth Service

300
1-57

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 21 1957

42628

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10914**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE MISSOURI b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		c. CITY OR TOWN FESTUS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR FIRMAN DESLOGE INSTITUTION		d. STREET ADDRESS 535 SOUTH ADAMS, ST	
3. NAME OF DECEASED (Type or print) First LENA Middle SMITH Last		4. DATE OF DEATH 11-12-57	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY GENERAL HOUSE WORK	11. BIRTHPLACE (City and state or country) FESTUS, MO.
13a. FATHER'S NAME JACOB SMITH		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE **
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Ann. Buehler - Mrs.		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) Cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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? 2 YES <input type="checkbox"/> NO <input checked="" 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.) 4221	
20c. TIME OF INJURY Hour _____ Month, Day, Year a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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 Nov 10, 57 to Nov. 9, 57 and last saw her/him alive on Nov 9, 57 Death occurred at 9:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Destina Buehler		22b. ADDRESS Festus, Mo	22c. DATE SIGNED 11/13/57
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-16-57	23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY	23d. LOCATION (City, town, or county) (State) FESTUS, MISSOURI
24. FUNERAL DIRECTOR Central P. Pelitto Crystal City, Mo		25. DATE RECD. BY LOCAL REG. NOV 15 57	26. REGISTRAR'S SIGNATURE Carl Smith Mo m83

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

NOV 21 1957

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 *Quincy R. Politto*

Licensed Embalmer No. *3481*

P. O. Address *Crystal City*

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.