

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46635

STATE FILE NUMBER

FILED JAN 7 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3181

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission), a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis 4151</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>St. Louis Co. D.O.A.</u>			Length of stay in lb <u>D.O.A.</u>			d. STREET ADDRESS (If outside, give location) <u>3719 Rosette Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>VIOLET</u> Middle <u>SMITH</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>11-9-96</u>		9. AGE (In years last birthday) <u>61</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or county) <u>Little Rock, Ark.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>YOUNG, FRED Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Alice Paroh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Frank Smith</u> Address <u>3719 Rosette Lane</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>Acute pulmonary edema</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> 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) <u>4200</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>2 years</u>	
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 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>11-1-57</u> to <u>12-14-57</u> and last saw her alive on <u>12-9-57</u> Death occurred at <u>8:30</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <u>Joseph B. Vocea M.D.</u>				22b. ADDRESS <u>1325 S. Grand Av.</u>		22c. DATE SIGNED <u>12-15-57</u>	
23a. DATE OF CREATION OR REMOVAL (Specify) <u>Removal 12/18/57</u>		23b. DATE <u>12/18/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>	
24. FUNERAL DIRECTOR <u>Duehmann Harrial</u> ADDRESS <u>1905 Union</u>			25. DATE RECD. BY LOCAL REG. <u>12-16-57</u>		26. REGISTRAR'S SIGNATURE <u>Robert H. ...</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health & Welfare
 Public Health Service
 300
 1-56
 3
 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

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 *Warren A. Carver*

Licensed Embalmer No. *352*

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.