

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023765

STATE FILE NUMBER

6274

FILED JUL 14 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

S. 300
1-57
0

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Herrin</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>BARNES HOSPITAL</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>32 1513 W. Madison</u>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL MARIE SMITH</u>			4. DATE OF DEATH Month Day Year <u>JUNE 24, 1958</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>March 9, 1902</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>56</u> Months Days Hours Min.	
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>Home-maker</u>	11. BIRTHPLACE (City and state or country) <u>Elizabethtown, Pa. /</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>James R. Dale</u>		13b. MOTHER'S MAIDEN NAME <u>Annie E. Winters</u>		14. NAME OF HUSBAND OR WIFE <u>Andrew Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Andrew Smith 1513 W. Madison Herrin</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>INTRACRANIAL CLOT, POST-OPERATIVE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>MALIGNANT BRAIN TUMOR</u>					<u>1 YEAR</u>
DUE TO (c) <u>193.0</u>					
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? 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.)			
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 <u>JUNE 17, 1958</u> to <u>JUNE 24, 1958</u> and last saw ^{her} him alive on <u>JUNE 24, 1958</u> Death occurred at <u>9:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>FR Bradley</u> M. D.			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>6/24/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal Auto</u>		23b. DATE <u>6-26-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Herrin City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Herrin, Illinois</u>
24. FUNERAL DIRECTOR <u>Johnson F.H. Herrin, Illinois</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 27 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Occur, cancer, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *V. E. Morris*

Licensed Embalmer No. *3360*

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.