

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

58-042579  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2047  
FILED NOV 20 1958

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>                  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Clayton</u>  |                               | c. CITY OR TOWN <u>St. Louis Wellston</u>   |   |
| FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>DOA Cty. Hospital</u>   |                               | Length of stay in lb <u>DOA 2059</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>V E R N A M. S M I T H</u>   |                               | 4. DATE OF DEATH <u>Nov. 3, 1958</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 12, 1910</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>   | 11. BIRTHPLACE (City and state or country) <u>Amory, Mississippi</u>                                    |
| 13a. FATHER'S NAME <u>Claude Mayfield</u>  |                               | 13b. MOTHER'S MAIDEN NAME <u>Rosie Hill</u>   | 14. NAME OF HUSBAND OR WIFE <u>T. D. Smith</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>415-36-8514</u>  | 17. INFORMANT <u>Roy Mayfield</u> Address <u>5828 Etzel</u>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Heart Disease</u><br>DUE TO (c) <u>Chronic Nephropathy</u> |                               |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u><br><u>3 mos</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>6000</u>  |                               |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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 <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 <u>July 1958</u> to <u>Nov. 1958</u> and last saw her alive on <u>Nov. 3, 1958</u> Death occurred at <u>9:15 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.  |                               |   |   |
| 22a. SIGNATURE (Degree or title) <u>Calvin J. Goffney, M.D.</u>  |                               | 22b. ADDRESS <u>2616 N. Kingsleyway</u>   |   |
|  |                               | 22c. DATE SIGNED <u>Nov. 19, 1958</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE <u>11/8/1958</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>   |                               | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>   |   |
| 24. FUNERAL DIRECTOR <u>Charles J. Gates</u> ADDRESS <u>4107 Finney</u>  |                               | 25. DATE RECD. BY LOCAL REG. <u>11-6-58</u>   |   |
| 26. REGISTRAR'S SIGNATURE <u>Herbert B. Doula MD</u>   |                               |   |   |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Gupton Swan* .....

Licensed Embalmer No. *4580*.....

P. O. Address *4107 Finney*.....

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.