

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003516
STATE FILE NUMBER 378

JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSPITAL</i>		Length of stay in lb <i>Life</i>	d. STREET ADDRESS (If outside, give location) <i>223 2224 S. 11th.</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>DEBRAH Lynn SMITH</i>			4. DATE OF DEATH Month Day Year <i>1 9 59</i>			
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-5-1958</i>	9. AGE (In years last birthday)	10. FUNDER 1 YEAR Months Days <i>6 4</i>	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo. 0</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Roy Smith</i>	13b. MOTHER'S MAIDEN NAME <i>Pauline Gibson</i>	14. NAME OF HUSBAND OR WIFE <i>None</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Roy Smith, 2224 S. 11th St.</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital malformation of the heart.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>754.5</i>
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? 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.)
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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
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21. I attended the deceased from *1/7/59* to *1/9/59* and last saw her/him alive on *1/9/59*.
Death occurred at *10:30 p.m.* on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>David S. Johnson M.D.</i> (Degree or title)	22b. ADDRESS <i>1515 Lafayette Av.</i>	22c. DATED AND SIGNED <i>JAN 12 1959</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>1-12-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hite Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Biggers, Arkansas</i>
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24. FUNERAL DIRECTOR ADDRESS <i>McLAUGHLIN'S, 2301 Lafayette Ave.</i>	25. DATE RECD. BY LOCAL REG. <i>JAN 12 1959</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *James R. Chapman*
Licensed Embalmer No. *425*
P. O. Address *A. Law*

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.