

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030806

FILED VS AUG 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **8 7244** STATE FILE NUMBER

| | | | |
|---|--|---|--|
| 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 St. Louis | | Length of stay in 1b 50 Yrs. | c. CITY OR TOWN St. Louis |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION E/R to City Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 218 S. 4th |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

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|-------------------------------------|-------------|--------|--------------|------------------|-------|-------------|------|
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| | John | | Smith | 8-1- | | 1959 | |

| | | | | | | | | |
|-----------------------|----------------------------------|---|-------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1-6-1887 | 9. AGE (last birthday) 72 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
|-----------------------|----------------------------------|---|-------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (City and state or country) New York, N.Y. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Unk Smith | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE |
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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) No | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT Raymond Smith, 2819a Victor | Address |
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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | Compound fractures both legs. | |
| CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Subdural hemorrhage | |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Struck by car | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED (Enter name of entity in PART 18 if item 18.) Struck by car |
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|--|--|---|--------|-------|
| 20c. TIME OF INJURY Hour 8:57 p.m. Month, Day, Year 8/1/59 | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Street | 20f. CITY, TOWN, OR LOCATION St. Louis Mo | COUNTY | STATE |
|--|--|---|--------|-------|

| | | | |
|---|---|--------|-------|
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20f. CITY, TOWN, OR LOCATION St. Louis Mo | COUNTY | STATE |
|---|---|--------|-------|

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|-------------------------------------|--------------------------------|-----------------------------------|-----------------------------------|
| 22a. SIGNATURE Paul Simon | (Degree) Deputy Coroner | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 8/5/59 |
|-------------------------------------|--------------------------------|-----------------------------------|-----------------------------------|

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|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 8-6-59 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. |
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| 24. FUNERAL DIRECTOR McLaughlin Funeral Home, Inc. | ADDRESS St. Louis, Mo. | 25. DATE RECD. BY LOCAL REG. AUG 5 '59 | 26. REGISTRAR'S SIGNATURE Paul Smith, M.D. |
|--|----------------------------------|--|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

H. G. Farris

Licensed Embalmer No.

338

P. O. Address

St. Louis

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.