

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037299

FILED VS NOV 6 1959

STATE FILE NUMBER

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 27

INDEXED

1. PLACE OF DEATH a. COUNTY ST Charles Co		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mo b. COUNTY St Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dardenne		Length of stay in 1b 6 Months	c. CITY OR TOWN O'Fallon Mo Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location), HOSPITAL OR INSTITUTION His Home		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route No I Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Ralph W Smith			4. DATE OF DEATH Month Day Year Oct, 27-1959		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7-1918	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	10b. KIND OF BUSINESS OR INDUSTRY Car Pool	11. BIRTHPLACE (City and state or country) ST Louis Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Marvin Smith	13b. MOTHER'S MAIDEN NAME Anna Davis	14. NAME OF HUSBAND OR WIFE Hazel Smith
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and type of service) Navy Second world war	16. SOCIAL SECURITY NO. 496-I4-2I70	17. INFORMANT Address Mrs Hazel Smith O'Fallon Mo
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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) Shot gun wound		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) self-inflicted.	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Shotgun wound self inflicted
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20c. TIME OF INJURY Hour a.m. p.m. 1.00AM	Month, Day, Year 10-27-59
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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.) Home	20f. CITY, TOWN, OR LOCATION COUNTY STATE Near O'Fallon, Missouri-St. Chas Co. Mo.
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21. I attended the deceased from **held inquest**, to on **Oct. 28 & 59** and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Marvin Muehberg Crown</i>	22b. ADDRESS <i>Wentzville Mo. Oct 28-59</i>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE *10/30/59	23c. NAME OF CEMETERY OR CREMATORY Mt Pleasant Cemetery	23d. LOCATION (City, town, or county) (State) New Florence Mo.
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24. FUNERAL DIRECTOR Baker Funeral Home	ADDRESS New Florence Mo	25. DATE RECD. BY LOCAL REG. 11/4/1959	26. REGISTRAR'S SIGNATURE <i>Ed H. Kelly</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 6 1959

NOV 12 1959

DEC 17 1959

DEC 14 1959

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 *O B Baker*

Licensed Embalmer No. 3375

P. O. Address New York

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.