

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 9 6 6

FILED VS. JAN - 4 1960

210961

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	Length of stay in 1b	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3104 Easton
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Floyd Middle Christopher Last Smith			4. DATE OF DEATH Month 11 Day 24 Year 59			
---	--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/28/1898	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Hod Carrier	11. BIRTHPLACE (City and state or country) East St. Louis, Ill.	12. CITIZEN OF WHAT COUNTRY U. S. A.
---	---	---	--

13a. FATHER'S NAME THOMAS SMITH	13b. MOTHER'S MAIDEN NAME SARAH DILL	14. NAME OF HUSBAND OR WIFE NONE
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I.	16. SOCIAL SECURITY NO. 495-14-7457	17. INFORMANT Marlon Smith, 1124 Market Street,	Address E. St. Louis, Ill.
---	---	---	-----------------------------------

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 Undet.
IMMEDIATE CAUSE (a) Cerebral Thrombosis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 332x		
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 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 _____ a.m. _____ p.m. Month, Day, Year	
---	--

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
--	--	--

21. I attended the deceased from 11-17-59 to 11-24-59 and last saw him alive on 11-24-59 Death occurred at 9:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <i>Robert J. Moore</i>	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 11-25-59
--	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/30/59	23c. NAME OF CEMETERY OR CREMATORY GREENWOOD	23d. LOCATION (City, town, or county) (State) ST. LOUIS, Missouri
--	------------------------------	--	---

24. FUNERAL DIRECTOR <i>Thurmond's Office</i>	ADDRESS 2114 Missouri Ave. E. St. Louis, Ill.	25. DATE RECD. BY LOCAL REG. NOV 27 1959	26. REGISTRAR'S SIGNATURE <i>Marlon Smith, M.D.</i>
--	---	--	--

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank Prakoff

Licensed Embalmer No. 4356
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.