

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CITY HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>4113 CHOUTEAU</u>	

3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>E.</u> Last <u>SMOCK</u>			4. DATE OF DEATH Month <u>OCT</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 18 1888</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED DAY LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>ILLINOIS</u>	
12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>		13. FATHER'S NAME <u>UNKNOWN SMOCK</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>DOLLIE SMOCK</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.		17. INFORMANT Address <u>DOLLIE SMOCK 4113 CHOUTEAU</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Massive Gastric Hemorrhage
Gastrovascular Prolapsus; Gastrovascular
Intoxication; Arterial Embolism
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Brain Syndroma, Hemorrhage
 DUE TO (c) Arteriosclerosis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) she died when struck by car operated by her
 PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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 date of injury in PART II of item 18.) <u>she was struck by car about 4:29 p.m. on</u>			
20c. TIME OF INJURY Hour <u>11:45</u> a.m. Month, Day, Year <u>September 30 1960</u> <u>at 1845 am.</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>18 Street</u>		20f. CITY, TOWN, OR LOCATION <u>St Louis Mo</u>		

21. I attended the deceased from 135A to her and last saw him alive on 135A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Samuel E. Ingle</u>	(Degree or title)	22b. ADDRESS <u>1300 Elm</u>	22c. DATE SIGNED <u>10/24/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>10-25-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS CO. MO.</u>
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24. FUNERAL DIRECTOR <u>Thomas Ruto</u>	ADDRESS <u>2906 Prairie</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 24 1960</u>	26. REGISTRAR'S SIGNATURE <u>Lead Smith M.D.</u>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.