

1. PLACE OF DEATH a. COUNTY St. Louis Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP OR TOWN) St. Louis Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 18-900		d. STREET ADDRESS (If outside, give location) WEEK	

3. NAME OF DECEASED (Type or print) First TE Middle SMITH		4. DATE OF DEATH Month 12 Day 14 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1905
9. AGE (last birthday) 65	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEEK	10b. KIND OF BUSINESS OR INDUSTRY WEEK	11. BIRTH PLACE (City and state or country) WEEK	12. CITIZEN OF WHAT COUNTRY UNK
13a. FATHER'S NAME WEEK	13b. MOTHER'S MAIDEN NAME WEEK	14. NAME OF HUSBAND OR WIFE WEEK	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) WEEK	16. SOCIAL SECURITY NO. WEEK	17. INFORMANT W. O. Smith Address 1300 Clark
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the liver DUE TO (b) Hepatitis DUE TO (c) Chronic Hypertensive		INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Myo Carditis, 581-0		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 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 045 Month, Day, Year 1-31-61			

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 St. Louis, Mo.	COUNTY St. Louis	STATE Mo.
21. I attended the deceased from _____, to _____ and last saw her/him live on _____ Death occurred at 1300 Clark on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE Joseph M. Swan Deputy (Degree or title)		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 1-9-61
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 1-31-61	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

24. FUNERAL DIRECTOR Rowland Mortuary Svc. ADDRESS 4104-06 Manchester	25. DATE RECD. BY LOCAL REG. JAN 19 1961	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
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 _____

Licensed Embalmer No. _____

P. O. Address _____

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