

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-023600

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1730

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>WEBSTER GROVES</u>		c. CITY OR TOWN <u>WEBSTER GROVES</u>	
Length of stay in 1b <u>2 MO.</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>228 CHESTNUT</u>		d. STREET ADDRESS (If outside, give location) <u>228 CHESTNUT</u>	
Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>ANDREW</u> Last <u>SMITH</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1961</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/1961</u>	9. AGE (last birthday) IF UNDER 1 YEAR: Months <u>2</u> Days <u>3</u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>EUGENE BATTLE SMITH JR.</u>	13b. MOTHER'S MAIDEN NAME <u>MARTHA KIEFFER</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>E.B. SMITH JR.</u> Address <u>228 CHESTNUT WEBSTER GROVES</u>
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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) <u>Acute Respiratory Insufficiency</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute Interstitial Pneumonia</u>	
	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.
Death occurred at 7:15A _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) <u>John C. Murphy MD Asst. Health Commissioner</u>	22b. ADDRESS <u>801 S. Brentwood Clayton Mo.</u>	22c. DATE SIGNED <u>6-26-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>22 JUNE 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>
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24. FUNERAL DIRECTOR <u>Arthur J. Donnelly 3846 Lindbergh</u>	25. DATE RECD. BY LOCAL REG. <u>6-21-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

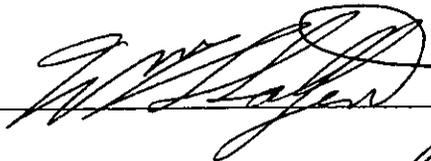
MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 4629

P. O. Address 3849 Leavelle

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.