

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

8644

-61-034952
STATE FILE NUMBER

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

FILED SEP 21 1961

DATE AMENDED

INSTEAD OF THIS RECORD FILE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo 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 type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FIRMIN Destoge			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3004 LOUISIANA		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) EDWARD J. SCHMIDT-SMITH				4. DATE OF DEATH Month SEPT Day 15 Year 1961			
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 AUG 30 1887	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME MATTHEW SMITH			13b. MOTHER'S MAIDEN NAME ELIZABETH BROWN			14. NAME OF HUSBAND OR WIFE KINNIE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no; unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address KINNIE SMITH 3004 LOUISIANA		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adenocarcinoma of prostate with generalized metastases DUE TO (b) with generalized metastases DUE TO (c) 177X						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) broncho pneumonia, auricular fibrillation						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 July 1958 , to 9-15-61 and last saw her/him alive on 9-14-61 . Death occurred at 6:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE J. M. Macnish (Degree or title) M.D.				22b. ADDRESS 4405 W. Pine St. St. Louis		22c. DATE SIGNED 9-16-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE SEPT 18, 1961		23c. NAME OF CEMETERY OR CREMATORY VAL HALLA CEM.		23d. LOCATION (City, town, or county) (State) ST. Louis Co Mo	
24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois				25. DATE RECD. BY LOCAL REG. SEP 18 1961		26. REGISTRAR'S SIGNATURE Loard Smith. M.D.	

11/18/1917
Sof

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 James O. Dill

Licensed Embalmer No. 4347

P. O. Address 2506 Annie

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.