

**MOURN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-042911**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**318**

Primary Registration District No. **1003**

Registrar's No. **11151**

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_  
**FILED DEC 12 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>4105 Washington</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Ulysess</b> Middle <b>Smith</b> Last			4. DATE OF DEATH Month <b>11</b> Day <b>28</b> Year <b>61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 26 1900</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PENSIONER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and state or country) <b>MASONS TENN</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>CHARLES SMITH</b>		13b. MOTHER'S MAIDEN NAME <b>VIRGINIA OWENS</b>		14. NAME OF HUSBAND OR WIFE <b>DECEASED</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ERMA SMITH 4105 WASH. AVE</b>	

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) <b>Uremia</b>			<b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Bladder Neck Obstruction</b>		<b>Undet.</b>
	DUE TO (c) <b>Bilateral Pyelonephritis</b> <b>6000.</b>		<b>Undet.</b>
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 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 _____ 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 <b>10-21-61</b> to <b>11-28-61</b> and last saw him alive on <b>11-28-61</b>		Death occurred at <b>9:10</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS <b>2601 N. Whittier Street</b>	22c. DATE SIGNED <b>11-29-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>12-5-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK DALE</b>	23d. LOCATION (City, town, or county) (State) <b>LEMAI MO</b>
24. FUNERAL DIRECTOR <b>RELIABLE FUNERAL SWS 1399 UNION</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 30 1961</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DATE OF DEATH

DOCUMENT

SHOULD READ

ITEM NO.

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 Clarence Green

Licensed Embalmer No. 4755

P. O. Address 1389 Uni

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.