

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040760

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10153**

FILED OCT 29 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE *Missouri* b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN *St. Louis* Length of stay in 1b *25 yrs*

c. CITY OR TOWN *St. Louis* Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION *De Paul Hospital* Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) *3110 a Prairie Ave* Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last *Harvey Cassius Smith*

4. DATE OF DEATH Month Day Year *October 21, 1962*

5. SEX *Male* 6. COLOR OR RACE *White* 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH *11/5/07* 9. AGE (last birthday) *54*

IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Foreman* 10b. KIND OF BUSINESS OR INDUSTRY *McDonald Aircraft Co* 11. BIRTHPLACE (City and state or country) *Mt. Grove Mo.* 12. CITIZEN OF WHAT COUNTRY *U.S.A.*

13a. FATHER'S NAME *Charles Smith* 13b. MOTHER'S MAIDEN NAME *Mabel* 14. NAME OF HUSBAND OR WIFE *Bonnie Lee Smith*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) *no none* 16. SOCIAL SECURITY NO. 17. INFORMANT Address *Mrs. Bonnie L Smith 3110 a Prairie Ave*

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *HYPERNEPHROMA LEFT KIDNEY* INTERVAL BETWEEN ONSET AND DEATH *3 yrs*

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) *180x*

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 1960* to *Oct 21, 1962* and last saw ^{her}him alive on *Oct 21, 1962*

Death occurred at *10:00* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *John Kiley MD* 22b. ADDRESS *6807 W. Florissant* 22c. DATE SIGNED *10/24/62*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 23b. DATE *Oct 24, 1962* 23c. NAME OF CEMETERY OR CREMATORY *Calvary Cemetery* 23d. LOCATION (City, town, or county) (State) *St. Louis, Missouri*

24. FUNERAL DIRECTOR ADDRESS *Shepard Funeral Home 1167 Hamilton Ave* 25. DATE RECD. BY LOCAL REG. *OCT 23 1962* 26. REGISTRAR'S SIGNATURE *John Smith. M.D.*

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF

