

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044893

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11113

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

FILED NOV 26 1962

VS 300
Rev. 4/59

1

2 **21**

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4 **0**

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11 **1265-0**

13

65

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

12/3/62

8/4/1898 & 64

DOCUMENT OWN BIRTH RECORD

8 & 9 8/4/1897 & 65

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | |
|---|--|--|-------|---|--|---|--|--|------|--|--|---|--|-------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | | c. CITY OR TOWN | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| St. Louis | | St. Louis | | | | Mo. | | St. Louis | | St. Louis | | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | | | Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| Lutheran Hospital | | | | | | 5506 Nottingham Ave. | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First | | | Middle | | | Last | | | 4. DATE OF DEATH Month Day Year | | | | | |
| HARRY | | | J. | | | SMITH | | | | | | Nov. 17 1962 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (last birthday) | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HR Hours Min. | | | | | |
| Male | | White | | | | 8-4-1898 | | 64 65 | | | | | | | | | |
| 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) | | | | 12. CITIZEN OF WHAT COUNTRY | | | | | |
| Switchman (Retired) Bell Telephone Co. | | | | Bell Telephone Co. | | | | Natchez, Miss. | | | | U.S.A. | | | | | |
| 13a. FATHER'S NAME | | | | 13b. MOTHER'S MAIDEN NAME | | | | 14. NAME OF HUSBAND OR WIFE | | | | | | | | | |
| John Smith | | | | Marguerite Della Smith | | | | Laura Smith | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | | | 17. INFORMANT Address | | | | | | | | | | | |
| Yes World War I | | | | | | Laura Smith 5506 Nottingham Ave. | | | | | | | | | | | |
| 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) | | | | | | | | | | | | ? | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | | | ? | | | | | |
| DUE TO (b) | | | | | | | | | | | | ? | | | | | |
| 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. | | | | | |
| 260x | | | | | | | | | | | | <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 | | 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 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 <u>Nov 6-62</u> to <u>Nov 17</u> and last saw him alive on <u>Nov. 16-62</u> | | | | | | | | | | | | | | | | | |
| Death occurred at <u>8:12 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) | | | | | | 22b. ADDRESS | | | | | | 22c. DATE SIGNED | | | | | |
| <u>W. W. Wagener M.D.</u> | | | | | | <u>477 Morganford Rd</u> | | | | | | <u>11/19/62</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City, town, or county) | | | | STATE | | | | | |
| Removal | | Nov. 20, 1962 | | Lakewood Park Cemetery | | | | St. Louis Co., Mo. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25. DATE RECD. BY LOCAL REG. | | | | | | 26. REGISTRAR'S SIGNATURE | | | | | |
| Kriegshauser 4228 S. Kingshighway Blvd. | | | | | | NOV 19 1962 | | | | | | Loan Smith, M.D. | | | | | |

USE BLACK INK OR TYPEWRITER RIBBON

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 Edwin R. McFerrill

Licensed Embalmer No. 3024
P. O. Address St. Louis Mo

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.

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