

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-018244

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3958** STATE FILE NUMBER

FILED APR 17 1963

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 checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS U. HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2915 CAROLINE ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EMMA Middle SMITH Last			4. DATE OF DEATH Month 4 Day 5 Year 63				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/3/1888	9. AGE (last birthday) 75 YRS.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
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) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME PHILIP SMITH			13b. MOTHER'S MAIDEN NAME MARY DEGUIRE		14. NAME OF HUSBAND OR WIFE NONE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO		16. SOCIAL SECURITY NO.		17. INFORMANT CHARLES CLAYTON 611 OLIVE ST. (1) Address			

18. CAUSE OF DEATH (Enter only one cause per line for Part I) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Abscess DUE TO (b) Perforated diverticulum of Transverse Colon 2 weeks DUE TO (c) 55-27-1		INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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 3-24-63 to 4-5-63 and last saw her alive on 4-5-63 Death occurred at 4:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>William J. Tierney MD</i> (Degree or title)		22b. ADDRESS 1325 S. Grand Ave		22c. DATE SIGNED 4-5-63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4/10/63	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION		23d. LOCATION (City, town, or county) (State) ST. LOUIS CO., MO.

24. FUNERAL DIRECTOR E. J. SCHNUR ADDRESS 3125 LAFAYETTE AVE.	25. DATE RECD. BY LOCAL REG. APR 8 1963	26. REGISTRAR'S SIGNATURE <i>Loan Smith M.D.</i>
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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 INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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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 Harvey Kahle

Licensed Embalmer No. 4596

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.