

S. No. 300
V. 10.48

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14177
Registrar's No. 3714

318

1008

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution) a. STATE <u>Kentucky</u> b. COUNTY <u>Marshall</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (In this place) <u>23 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Calvert City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Barnes Hospital</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>James</u>		b. (Middle) <u>Floyd</u>		c. (Last) <u>Smith</u>	
				4. DATE OF DEATH (Month) (Day) (Year) <u>April 23 1949</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>June 10, 1930</u>	
				9. AGE (In years last birthday) <u>18</u>		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deckhand</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Marshall Co., Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Eugene Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Pauline Holley</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Eugene Smith, Calvert City, Ky.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Monocytic leukemia</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>74a</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>20 1/2</u>			
22. I hereby certify that I attended the deceased from <u>April 1, 1949</u> , to <u>April 23, 1949</u> , that I last saw the deceased alive on <u>April 23, 1949</u> , and that death occurred at <u>3:30P m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Ralph V. Giselman M.D.</u>				23b. ADDRESS <u>Barnes Hospital,</u>		23c. DATE SIGNED <u>4/23/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4-24-49</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Calvert City, Ky.</u>	
DATE REC'D BY LOCAL REG. <u>APR 25 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe, 4700 Washington Blvd.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, fact should be so stated above.