

FILED MAY 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17716**  
**4188**  
Registrar's No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. <b>17716</b>		Registrar's No. <b>4188</b>		
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, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		d. STREET ADDRESS (If rural, give location) <b>4010 Lee Ave.</b>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4010 Lee Ave. /</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>May 5 1949</b>						
3. NAME OF DECEASED (Type or Print) a. (First) <b>Philip</b>			b. (Middle) <b>A.</b>			c. (Last) <b>Smith</b>			5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>		8. DATE OF BIRTH <b>June 29, 1887</b>		9. AGE (In years last birthday) <b>61</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Robert Smith</b>				13b. MOTHER'S MAIDEN NAME <b>unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Emma L. Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Ann Cochran 322 Youngs Ave.,</b>					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Myocarditis</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Endocarditis</b>						INTERVAL BETWEEN ONSET AND DEATH _____		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>94</b>		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? <b>4201</b>								
22. I hereby certify that I attended the deceased from <b>March, 1949</b> , to <b>May, 1949</b> that I last saw the deceased alive on <b>5/4, 1949</b> , and that death occurred at <b>7:00 P.m.</b> , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) <b>Hullison O. Mowbray M.D.</b>				23b. ADDRESS <b>3625 Fairlie</b>				23c. DATE SIGNED <b>5/6/49</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>May 9, 1949.</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri.</b>				
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>MAY 6 REG. J. B. Sasser</b>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Math Hermann &amp; Son, Inc. 2161 E. Fair Ave.</b>						

(Licensed Embalmer's Statement on Reverse Side)

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

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_

*Glen W. Hay*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. *3737C*

P. O. Address *St. Louis, Missouri*

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.