

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32197
State File No. 8269
Registrar's No.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) township)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION 5303 Walsh St.		(If not in hospital or institution, give street address or location)		d. STREET ADDRESS (If rural, give location) 14 - 5303 Walsh St.			
3. NAME OF DECEASED (Type or Print) ADELINE (ADDIE)		a. (First)		b. (Middle)			
c. (Last) SMITH		4. DATE OF DEATH Sep't. 24 1949		(Month) (Day) (Year)			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow			
8. DATE OF BIRTH Nov. 29, 1880		9. AGE (in years last birthday) 68		IF UNDER 1 YEAR Months 9 Days 25			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Arkansas			
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Redman Rice		13b. MOTHER'S MAIDEN NAME Unknown			
14. NAME OF HUSBAND OR WIFE Late L. G. Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.			
17. INFORMANT'S SIGNATURE OR NAME James Flanagan		ADDRESS 5303 Walsh St.					
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary thrombosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input 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) St. Louis Mo.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H201			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:45 A.M., from the causes and on the date stated above.							
23a. SIGNATURE Joseph J. ...		(Degree of title) ... M.D.		23b. ADDRESS 1300 Clark			
23c. DATE SIGNED 9/26/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sep. 27, 1949			
24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.					
DATE REC'D BY LOCAL REG. SEP 26 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauer 4228 S. Kingshighway Bl			

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.

Student
Student Embalmer

Signed Richard W. Stover

Licensed Embalmer No. 4007

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.