

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32199

8547

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
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>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</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>5660 Kingsbury</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>5660 Kingsbury</b>					
3. NAME OF DECEASED (Type or Print)			a. (First) <b>MABEL</b>		b. (Middle) <b>COLLINS</b>		c. (Last) <b>SMITH.</b>		
4. DATE OF DEATH		(Month) <b>Oct. 1,</b>		(Day) <b>1949</b>		(Year)			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Jan. 1, 1887</b>			
9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 1 HR. Hours _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <b>Sales Lady; Kiene's</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Nova Scotia, Canada</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13a. FATHER'S NAME <b>William Collins</b>		13b. MOTHER'S MAIDEN NAME <b>Ida Maria Woodbury.</b>			
14. NAME OF HUSBAND OR WIFE <b>Fred Smith.</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give no. or unknown) (If yes, give no. or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-16-8427</b>			
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. C.W. Hoevel;</b>				ADDRESS <b>8715 Hoover 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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Stomach</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <b>6 months</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Stomach</b>				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>St. Louis, MO</b>		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? <b>157X</b>		22. I hereby certify that I attended the deceased from <b>June 18, 1949</b> , to <b>Oct 1, 1949</b> , that I last saw the deceased alive on <b>Oct 1, 1949</b> , and that death occurred at <b>4:50 P</b> m., from the causes and on the date stated above.		23a. SIGNATURE (Degree or title) <b>M. D. Stone</b>			
23b. ADDRESS <b>4500 Olive St</b>		23c. DATE SIGNED <b>Oct 3/49</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10/4/1949</b>			
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <b>Wahoo, Nebraska</b>		DATE REC'D BY LOCAL REGISTRAR <b>OCT 4 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>			
25. FUNERAL DIRECTOR'S SIGNATURE <b>C.R. Lupton &amp; Sons</b>		ADDRESS <b>7233 Delmar Bld</b>		(Licensed Embalmer's Statement on Reverse Side)					

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

No. 300  
10-48

8547

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address *St Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do the above constitutes grounds for revocation of license.)

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

