

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35594

State File No.

318

1003

Registrar's No. 8839

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4421 West Belle Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4421 West Belle Avenue			

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) William	b. (Middle) P.	c. (Last) Smith	(Month) (Day) (Year) 10/10/49
5. SEX Male	6. COLOR OR RACE 2 - Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 9/14-1866
9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pullman Ptr. Instr.	11. BIRTHPLACE (State or foreign country) Columbia, Tennessee
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Retired	12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Benjamin F. Smith	13b. MOTHER'S MAIDEN NAME Mary Ann Pillow	14. NAME OF HUSBAND OR WIFE Mattie Smith
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Blanche Davis	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH 6 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of prostate		
	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. Arteriosclerotic Heart Dis.		2 yrs	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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
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? 177X

22. I hereby certify that I attended the deceased from May, 1949, to Oct 10, 1949, that I last saw the deceased alive on Oct 10, 1949, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE <i>W. B. Lassiter</i>	(Degree or title) 0	23b. ADDRESS 4242 Easton Avenue	23c. DATE SIGNED 10-13-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/15/49	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. OCT 14 1949	REGISTRAR'S SIGNATURE <i>W. B. Lassiter</i>	25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates	ADDRESS 4107 Finney Avenue
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed John R. Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.