

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42977

105969

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

State File No. _____
Register's No. 10577

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased, lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		a. STATE Iowa b. COUNTY Linn	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cedar Rapids	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 117 - 403 First St. S.W.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) HOMER	b. (Middle) C.	c. (Last) SMOTHERS	(Month) OF	(Day)	(Year)
5. SEX Male			8. DATE OF BIRTH Jan. 16, 1909		
6. COLOR OR RACE White			9. AGE (In years last birthday) 40		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Atkins, Minnesota		
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Edward Smothers	13b. MOTHER'S MAIDEN NAME Winnie Dudley	14. NAME OF HUSBAND OR WIFE None
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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. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gifford Smothers, Cedar Rapids, Iowa.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Pulmonary tuberculosis, far advanced		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

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) 13
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 002X
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22. I hereby certify that I attended the deceased from 12/1/49, 19__, to 12/7/49, 19__, that I last saw the deceased alive on 12/7/49, 19__, and that death occurred at 8:00am., from the causes and on the date stated above.

23a. SIGNATURE John T. Korkler, M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 12/7/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-8-49	24c. NAME OF CEMETERY OR CREMATORY Troy Mills	24d. LOCATION (City, town, or county) (State) Troy Mills, Iowa.
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DATE REC'D BY LOCAL REG. DEC 8 1949	REGISTRAR'S SIGNATURE J. B. Busater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10577

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.....

F. Wm. Becken
3653

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.