

FILED JAN 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1221 Kussella
State File No. **43173**
Registrar's No. **04831**

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069

1. PLACE OF DEATH a. COUNTY StLouis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Texas b. COUNTY Lamar	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Paris	
d. FULL NAME OF HOSPITAL OR INSTITUTION StMarys Hospital		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) NOAH b. (Middle) S c. (Last) SMITH		4. DATE OF DEATH (Month) (Day) (Year) 12-31-1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) Widowed	8. DATE OF BIRTH 7-22-1872
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Grocer
11. BIRTHPLACE (State or foreign country) Delta County Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME unobtainable		13b. MOTHER'S MAIDEN NAME Nancy Carr	
14. NAME OF HUSBAND OR WIFE Ida		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Don't Know	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Louis Smith Paris Texas	
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) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 7 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis Heart Dis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.0	
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)			
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?			
22. I hereby certify that I attended the deceased from Dec 23, 1949 , to Dec 31, 1949 , that I last saw the deceased alive on Dec 30, 1949 , and that death occurred at 8 m., from the causes and on the date stated above.			
23a. SIGNATURE Kussella (Degree or title) M.D.		23b. ADDRESS 3720 Washington	
23c. DATE SIGNED 12-31-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 12-31-49	
24c. NAME OF CEMETERY OR CREMATORY EMERALD		24d. LOCATION (City, town, or county) (State) PARIS Texas	
DATE REC'D BY LOCAL REG. 12-31-49		REGISTRAR'S SIGNATURE Herbert R. Dombey, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.		ADDRESS 6202 St. Louis Ave. St. Louis 10, Mo.	

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 _____

Licensed Embalmer No. 4053

P. O. Address StLouis 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.