

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **15012**

BIRTH NO. **24205-50** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3709**

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

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 town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) 6 days		d. STREET ADDRESS (If rural, give location) 3012 Missouri Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Mary Ellen		b. (Middle) Grace	
c. (Last) Smerek		4. DATE OF DEATH (Month) (Day) (Year) April 22, 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 15, 1950
9. AGE (In years last birthday) 6		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME John Smerek		13b. MOTHER'S MAIDEN NAME Frances Grill	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME John Smerek ADDRESS 3012 Missouri Ave.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tracheo-Esophageal Fistula ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenital DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Broncho-pneumonia - Bilateral	
19a. DATE OF OPERATION 4-17-50		19b. MAJOR FINDINGS OF OPERATION Tracheo-Esophageal Fistula (Classical type)	
20. AUTOPSY? YES <input checked="" 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)			
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? 756.2			
22. I hereby certify that I attended the deceased from 4-17-1950 , to 4-22-1950 , that I last saw the deceased alive on 4-21-1950 , and that death occurred at 2:50 Am. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Joseph L. Lucido M.D.		23b. ADDRESS Mo. Theatre Bldg.	
23c. DATE SIGNED 4-22-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE April 22, 1950	
24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. APR 24 1950		REGISTRAR'S SIGNATURE L. B. Lasater	
25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons		ADDRESS 2630 Gravois Ave.	

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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 Herman A. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.