

FILED MAY 10 1950

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 15015
4007

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>22 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		2029	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>2329 Clark Ave</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Georgia</u>		b. (Middle)		c. (Last) <u>Smith</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 30 1950</u>	
5. SEX <u>Fem 3</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>Abt. 1896</u>	9. AGE (In years last birthday) <u>Abt. 54</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>	11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <u>Henry Lowell</u>		13b. MOTHER'S MAIDEN NAME <u>Harriet Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>			
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. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Record</u>		ADDRESS	
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) <u>Carcinoma of Cervix, far advanced with Local Metastases</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Undetermined</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) <u>Ill</u>			
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?			
22. I hereby certify that I attended the deceased from <u>4-4</u> , 19 <u>50</u> , to <u>4-30</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4-30</u> , 19 <u>50</u> , and that death occurred at <u>1:20p.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. M. D.</u>				23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>5-2-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>5/4/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Booker T. Washington</u>		24d. LOCATION (City, town, or county) (State) <u>Centerville Twp, Ill</u>		
DATE REC'D BY LOCAL REG. <u>MAY 3 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R. M. C. Green, 3517 Laclede Ave.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

W. B. Green

Signed
Student Embalmer

Licensed Embalmer No. *4428*

P. O. Address *St. Louis, Mo*

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.