

FILED NOV 3 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

35344

State File No. _____

8934

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY None		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) East St. Louis 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Inf.		d. STREET ADDRESS (If rural, give location) 1419 Broadway	

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) _____ c. (Last) Smith			4. DATE OF DEATH (Month) (Day) (Year) Oct. - 20, 1950		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 15, 1880	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 1 Days 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Egypt, Mississippi /	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME Elizah Smith		13b. MOTHER'S MAIDEN NAME Martha A. Mosley		14. NAME OF HUSBAND OR WIFE Rosie L. Smith	
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 ADDRESS Mable Smith 1419 Broadsay	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Nephritis		
		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"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 592X	

22. I hereby certify that I attended the deceased from **10/18**, 19**50**, to **10/20**, 19**50**, that I last saw the deceased alive on **10/20**, 19**50**, and that death occurred at **3 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edgar F. Johnson M.D.		23b. ADDRESS 930 W. Second St.		23c. DATE SIGNED	
24a. BURIAL (CREMATION, REMOVAL) (Specify) S		24b. DATE Oct. 21, 1950		24c. NAME OF CEMETERY OR CREMATORY	
DATE RECD BY LOCAL REG. Oct 21 1950		REGISTRAR'S SIGNATURE J. B. Sadler		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS P. Q. Criggler 1036 Tudor Avenue	

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

John Johnson

X

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 K Cunningham

Licensed Embalmer No. 4776

P. O. Address 4107 Finney

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.