

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No. 10551			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2269			
d. FULL NAME OF HOSPITAL OR INSTITUTION Faith Hospital				d. STREET ADDRESS (If rural, give location) 2015 Mallinckrodt					
3. NAME OF DECEASED (Type or Print) a. (First) Martha T.		b. (Middle) Drysdale		c. (Last) Smith		4. DATE OF DEATH (Month) (Day) (Year) 12 10 1950			
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb 22-1888		9. AGE (In years last birthday) 62	10. MONTHS	11. HOURS	12. MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Thomas Caffrey			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE August Smith				
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. 488-18-9094B		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Virian Beckmann - 1111 E. John					
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) Peritonitis				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ruptured diverticulum of sigmoid flexure of colon.				DUE TO (c)				24 hrs.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				DIVERTICULUM					
19a. DATE OF OPERATION 12/9/50		19b. MAJOR FINDINGS OF OPERATION Peritonitis secondary to ruptured diverticulum				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? 578A					
22. I hereby certify that I attended the deceased from Dec 2, 1950, to Dec 10, 1950, that I last saw the deceased alive on Dec 9, 1950, and that death occurred at 10 a.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) J. Crasnick M.D.				23b. ADDRESS 1901 Madison St		23c. DATE SIGNED 12/11/50			
24a. BURIAL, CREMATION REMOVAL (Specify) Burial		24b. DATE 12-13-1950		24c. NAME OF CEMETERY OR CREMATORY Mem Park Cem		24d. LOCATION (City, town, or county) (State) St. Louis Mo			
DATE REC'D BY LOCAL REG. 153 DEC 21 1950		REGISTRAR'S SIGNATURE J. B. Forster		25. FUNERAL DIRECTOR'S SIGNATURE Edward Koch + Son		ADDRESS 3516 E. 14			

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.

Signed.....
Student Embalmer

Signed.....
Student Embalmer No.....
Ronald Yachup

Licensed Embalmer No. *3917*

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.