

FILED APR 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 10648
2953
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Illinois	b. COUNTY Madison
c. LENGTH OF STAY (If in this place) 2 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Collinsville Twp. 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If rural, give location) Rural, Lebonon Road	

3. NAME OF DECEASED (Type or Print)	a. (First) Willard	b. (Middle) R.	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) Mar. 29, 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec. 11, 1899	9. AGE (In years last birthday) 51	10. UNDER 1 YEAR 3 Months	11. UNDER 1 M. RES. 18 Days	12. UNDER 1 M. RES. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Work	10b. KIND OF BUSINESS OR INDUSTRY Emer. Elec. Co.	11. BIRTHPLACE (State or foreign country) Nashville, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Smith	13b. MOTHER'S MAIDEN NAME Nora Bridges	14. NAME OF HUSBAND OR WIFE
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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. 351-16-0300	17. INFORMANT'S SIGNATURE OR NAME Raymond J. Smith	ADDRESS E. St. Louis, Ill.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
	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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H/200
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22. I hereby certify that I attended the deceased from 3-26, 1951, to 3-29, 1951, that I last saw the deceased alive on 3-28, 1951, and that death occurred at 5 a. m., from the causes and on the date stated above.

23a. SIGNATURE J. B. Laster M.D.	(Degree or title)	23b. ADDRESS 539 N. Grand	23c. DATE SIGNED 3/29/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3/29/51	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope	24d. LOCATION (City, town, or county) (State) Belleville, Illinois
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DATE REC'D BY LOCAL REGISTER'S SIGNATURE MAR 28 1951 J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE John Kossely	ADDRESS E. St. Louis, Ill.
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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.....

not embalmed

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *John J. Kasaly*

Licensed Embalmer No. *6855 Ill*

P. O. Address *East St. Louis, Ill*

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.