

FILED JUN 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18612

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5129**

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 township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		STREET ADDRESS (If rural, give location) 4827 Anderson Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Alice b. (Middle) S. c. (Last) Smith			4. DATE OF DEATH (Month) (Day) (Year) June 2, 1951		
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH April 8, 1887	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR 1 month 1 Days 24 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME William Spyerer		13b. MOTHER'S MAIDEN NAME Mary McCue		14. NAME OF HUSBAND OR WIFE Mr. William 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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. William Smith, 4827 Anderson 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Herniaotomy. (textual)			INTERVAL BETWEEN ONSET AND DEATH 1 day
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 Partial Herniaotomy		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.) Home		21c. (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo.	

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? 561.3	
22. I hereby certify that I attended the deceased from May 24, 1951 , to June 7, 1951 , that I last saw the deceased alive on June 7, 1951 and that death occurred at 11:55 AM , from the causes and on the date stated above.					

23a. SIGNATURE [Signature]		(Degree or title)		23b. ADDRESS 1878 Madison		23c. DATE SIGNED 6-4-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 5, 1951		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL JUN 4 1951		REGISTRAR'S SIGNATURE S. B. Lassiter		FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		ADDRESS 3840 Lindell Blvd.	

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

Smith

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 _____

W. Van Matre

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.