

FILED JUL 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25657

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3070</u>		Registrar's No. <u>2674</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> <u>4057</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sublette Grove</u>		c. LENGTH OF STAY (in this place) <u>1 yr</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Sublette Grove</u> <u>4797</u>		d. STREET ADDRESS (If rural, give location) <u>9044 Watson Rd.</u> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>9044 Watson Rd.</u>				d. STREET ADDRESS <u>9044 Watson Rd.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Anna</u>		b. (Middle) <u>Johnson</u>		c. (Last) <u>Smith</u>	
4. DATE OF DEATH		(Month) <u>July</u>		(Day) <u>16,</u>		(Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, WIDOWED <u>Widowed</u>		8. DATE OF BIRTH <u>Sept. 2, 1874</u>		9. AGE (in years last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u> <u>4</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>John O. Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Della Metry 9044 Watson Rd.,</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>More than 1 yr.</u>	
<p>* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis of coronary arteries</u>				<u>Many years</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u>					
		DUE TO (c) _____					
19a. DATE OF OPERATION		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4201</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		19b. MAJOR FINDINGS OF OPERATION					
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) (m.)		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>Dec 23 1950</u> , to <u>July 16, 1951</u> , that I last saw the deceased alive on <u>July 16, 1951</u> , and that death occurred at <u>1:45 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>James B. Jones M.D.</u>		23b. ADDRESS <u>337 W. Lockwood Sublette Grove 19, Missouri</u>		23c. DATE SIGNED <u>July 16, 1951</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal via rail</u>		24b. DATE <u>7-17-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Staples, Minn.</u>	
DATE REC'D BY LOCAL REG. <u>7-17-51</u>		REGISTRAR'S SIGNATURE <u>Hubert P. Jones, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>MITTELBERG FUNERAL HOME, INC 73. W. LOCKWOOD AVE. W. G.</u>			

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 Me

working under my personal supervision.

Student Embalmer No.

Signed Edwin R. Remick

Signed.....
Student Embalmer

Licensed Embalmer No. 4283

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.