

No. 300  
10.48

FILED AUG 25 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH 1003

State File No. 28742  
7207

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2089	
d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hospital		d. STREET ADDRESS (If rural, give location) 8132 Church Rd 0	

3. NAME OF DECEASED (Type or Print) a. (First) Rosa b. (Middle) B. c. (Last) Smith			4. DATE OF DEATH (Month) (Day) (Year) Aug 12t, 1951			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 12th 1884	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wentworth, N.C.		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Robert Duncan	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Oliver W. Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Oliver W. Smith, 8132 Church Rd

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Glomerular Nephritis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Distal Nephritis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Aneurysm			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 260X

22. I hereby certify that I attended the deceased from July 15, 1951, to Aug 12, 1951, that I last saw the deceased alive on Aug 8, 1951, and that death occurred at 10:05 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm A Knight MD	23b. ADDRESS 820 N Broadway	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 8/15/51	24c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis, Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Diedrich F. Home 8319 Hallsferry
DATE REC'D BY LOCAL REG. AUG 13 1951	REGISTRAR'S SIGNATURE J Carl Smith MD	

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Robert M. Murray*

Licensed Embalmer No.

*3749*

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.