

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14805

State File No.

3639

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Clay			
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS, MO.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Flora		8/24	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				d. STREET ADDRESS (If rural, give location) 520 W. North Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) HARVEY		b. (Middle) L.		c. (Last) SMOTHERS		4. DATE OF DEATH (Month) (Day) (Year) 4 14 52	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 14, 1900		9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Wayne Co., Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME William Smothers		13b. MOTHER'S MAIDEN NAME Celia Flynn		14. NAME OF HUSBAND OR WIFE Goldie			
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. 361-05-0356		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Goldie Smothers, Flora, Ill.			
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) BRAIN TUMOR, MALIGNANT ANTECEDENT CAUSES Morbid 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.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) 193X			
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 4/11 , 19 52 ; to 4/14 , 19 52 , that I last saw the deceased alive on 4/14 , 19 52 , and that death occurred at 1:30P m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) JR Bradley MD				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 4/14/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-14-52	24c. NAME OF CEMETERY OR CREMATORY Elmwood		24d. LOCATION (City, town, or county) (State) Flora, Ill.		
DATE REC'D BY LOCAL REG. APR 17 1952		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.			

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 John J. Haines

Licensed Embalmer No. 4108

P. O. Address H. Haines MD

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.