

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3786**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0299**

FILED JAN 28 1953

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

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) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6034 Kingsbury Blvd.		c. LENGTH OF STAY (In this place) 2 yrs	
3. NAME OF DECEASED a. (First) Mary b. (Middle) c. (Last) Smith		4. DATE OF DEATH (Month) (Day) (Year) 1 - 11 - 1953	
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1 - 5 - 1863
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 90
11. BIRTHPLACE (City and State or Foreign Country) St. Peters, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Stephen Pohlmeier		13b. MOTHER'S MAIDEN NAME Theresa Jollie	14. NAME OF HUSBAND OR WIFE John 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 Mrs. Thos. Branch, 6034 Kingsbury
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) GENERALIZED ARTERIO SCLEROSIS INTERVAL BETWEEN ONSET AND DEATH INDEF	
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.		TERMINAL BRONCHOPNEUMONIA 2 days	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR	4500
22. I hereby certify that I attended the deceased from AUG 15, 1952 , to 11 JAN, 1953 , that I last saw the deceased alive on 11 JAN, 1953 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Robert A. Mayer M.D.		23b. ADDRESS 505 HUMBOLDT BLDG	23c. DATE SIGNED 1/12/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1/14/53	24c. NAME OF CEMETERY OR CREMATORY Lake Charles	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
DATE REC'D BY LOCAL REG. JAN 12 1953	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral 1905 Union Blvd.	

Dr. Robert Mayer
Humbolt Bldg.
no Tue hours
Mon & Wed 10-1
5-7

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 *Warren A. Carver*

Licensed Embalmer No. *3534*

P. O. Address _____

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.