

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12335
3160

State File No.

Registrar's No.

APR 4 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Wood River	
c. LENGTH OF STAY (in this place) 15 Days		d. STREET ADDRESS (If rural, give location) 718 Rice St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		e. COUNTY Madison	
3. NAME OF DECEASED (Type or Print) a. (First) Bertie		b. (Middle) Melva	
c. (Last) Smith		4. DATE OF DEATH (Month) (Day) (Year) Mar. 21 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 15, 1883
9. AGE (In years last birthday) 69	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter, Retired	10b. KIND OF BUSINESS OR INDUSTRY Oil Refinery	11. BIRTHPLACE (City and State or Foreign Country) Roodhouse, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Smith	13b. MOTHER'S MAIDEN NAME Luella Baird	14. NAME OF HUSBAND OR WIFE Lydia E. 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. 341-09-8694	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Albert N. Smith Waggoner,	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Thrombosis Cerebral vessel	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		vs. aal	
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 332X	
22. I hereby certify that I attended the deceased from 2/6, 1953 , to 3/21, 1953 , that I last saw the deceased alive on 3/21, 1953 , and that death occurred at 2:20 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) G. A. Brumic		23b. ADDRESS Beaumont Inn Bldg	
23c. DATE SIGNED 3/28/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/24/53	24c. NAME OF CEMETERY OR CREMATORY Upper Alton Cemetery	24d. LOCATION (City, town, or county) (State) Alton Illinois.
DATE REC'D BY LOCAL REG. MAR 24 1953	REGISTRAR'S SIGNATURE Robert H. Stroger	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Robert H. Stroger, Alton, Ill.	

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 H. Streep*

Licensed Embalmer No. 2474

P. O. Address Altamont, Ill.

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.