

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

12344

FILED MAR 18 1953

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State File No. 2299
 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, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2913 Lemp Street.		d. STREET ADDRESS (If rural, give location) 24 2913 Lemp Street., 0	
3. NAME OF DECEASED (Type or Print) a. (First) Wilma b. (Middle) c. (Last) Smith		4. DATE OF DEATH (Month) (Day) (Year) Feb 27, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Nov 4 1919
9. AGE (In years last birthday) 33		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Piedmont, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Smith		13b. MOTHER'S MAIDEN NAME Elsie West	
14. NAME OF HUSBAND OR WIFE Nil		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Ada Duerr, 2913 Lemp Street.	
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) acute Coronary Occlusion ANTECEDENT CAUSES DUE TO (b) Obesity & DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	
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) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR		4201	
22. I hereby certify that I attended the deceased from Oct 1952 , to Feb 27, 1953 , that I last saw the deceased alive on Feb 26, 1953 , and that death occurred at 3:35 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE J. W. McShane, M.D.		23b. ADDRESS 4500 Olive St. St. Louis Mo	
23c. DATE SIGNED 7/18/53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 2-28-53		24c. NAME OF CEMETERY OR CREMATORY City	
24d. LOCATION (City, town, or county) (State) Piedmont, Missouri.		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington	
DATE REC'D BY LOCAL REG. FEB 28 1953		REGISTRAR'S SIGNATURE J. C. Smith	

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.....

Lois J. Farmer

Licensed Embalmer No. *4788*

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.