

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34082

State File No.

FILED OCT 9 - 1953

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8626**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 3 weeks	c. CITY OR TOWN University City d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital		e. STREET ADDRESS (If rural, give location) 8321 Gannon Avenue	
3. NAME OF DECEASED (Type or Print)	a. (First) Alda	b. (Middle) King	c. (Last) Smith
	4. DATE OF DEATH (Month) (Day) (Year) Sept. 3, 1953		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec. 2, 1876
9. AGE (in years last birthday) 76		10. UNDER 1 YEAR Months	11. UNDER 24 Hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not done during most of working life) at home		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) Pinckneyville, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Jefferson F. King	
13b. MOTHER'S MAIDEN NAME Martha Jane Darrough		14. NAME OF HUSBAND OR WIFE Arthur C. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Carroll Smith		ADDRESS 8321 Gannon Avenue	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis INTERVAL BETWEEN ONSET AND DEATH Days of year	
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. 4222 F	
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) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) University City Missouri Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 13 - 53 8P.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fall causing fracture of right hip	
22. I hereby certify that I attended the deceased from Aug 13, 1953 , to Sept 3, 1953 , that I last saw the deceased alive on Aug 3, 1953 , and that death occurred at 7P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. A. Brown		23b. ADDRESS 3903 Olive	23c. DATE SIGNED 9/4/53
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE Sept. 5, 1953	24c. NAME OF CEMETERY OR CREMATORY Pinckneyville Cemetery	24d. LOCATION (City, town, or county) (State) Pinckneyville, Illinois
DATE REC'D BY LOCAL REG. SEP 4 1953	REGISTRAR'S SIGNATURE Carroll Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons 7233 Delmar Blvd.	

(Licensed Embalmer's Statement on Reverse Side)

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

3903 Olive Street
11-1 p.m.
LW 6211

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.....
Signature of Student Embalmer

Signed *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.