

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41583**

FILED NOV 25 1953

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>548</u>		Registrar's No. <u>2802</u>	
1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES</u>		c. LENGTH OF STAY (In this place) <u>20 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES 4627</u>		d. STREET ADDRESS (If rural, give location) <u>121 Thornton St. Webster</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		3. NAME OF DECEASED a. (First) <u>EUGENE</u> b. (Middle) <u>CLAYENCE</u> c. (Last) <u>SMITH</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>27</u> (Year) <u>53</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COL</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>5/21/1880</u>	
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 48 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>RETIRED P. Job</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Port Gibson Miss</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>Macie Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Macie Smith</u> ADDRESS <u>121 Thornton</u>			
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) <u>Arteriosclerotic Heart Disease</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Of Sclerosis of Coronary Arteries</u> DUE TO (c) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>  <u>Many years</u>  <u>many years</u>	
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) _____ 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 <u>Nov. 24, 1952</u> to <u>Oct 27, 1953</u> , that I last saw the deceased alive on <u>Oct 27, 1953</u> , and that death occurred at <u>10:30 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>James B. Jones</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>337 W. Lockwood Webster Groves, 19, Mo.</u>		23c. DATE SIGNED <u>10-29-53</u>	
24a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		24b. DATE <u>11/2/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON PARK</u>		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>10-30-53</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>SUSIE C Lewis</u> ADDRESS <u>22 Euclid Ave</u>			

SW (Licensed Embalmer's Statement on Reverse Side)

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

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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.

Signed.....  
Student Embalmer

Signed

*James A. Carter*

Licensed Embalmer No. *4681*

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.