0.300
0.48

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

FILED JAN 5 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44476

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11795

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place): 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Lane Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 2902 Wisconson

24 2249

3. NAME OF DECEASED (Type or Print)
a. (First): Carrie
b. (Middle):
c. (Last): Smith

4. DATE OF DEATH (Month) (Day) (Year): Dec. 13 1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 5 1896
9. AGE (In years last birthday): 57
If under 1 year: Months | Days
If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Wm. Moehle
13b. MOTHER'S MAIDEN NAME: Christine Freise
14. NAME OF HUSBAND OR WIFE: George Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: George Smith 2902 Wisconsin

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

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. —

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: No surgery
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 331X

22. *I hereby certify that I attended the deceased from* 12-13- *, 19*53*, to* 12-13- *, 19*53*, that I last saw the deceased alive on* 12-13-53 *, 19* *, and that death occurred at* 4 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: 4930 Lindell Blvd. St. Louis, Mo.
23c. DATE SIGNED: 12-14-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/17/53
24c. NAME OF CEMETERY OR CREMATORY: New St. Marcus Cem
24d. LOCATION (City, town, or county) (State): St. Louis Mo.

DATE REC'D BY LOCAL REG.: DEC 14 1953
REGISTRAR'S SIGNATURE: Karl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm. Schumacher 3013 Meramec

(Licensed Embalmer's Statement on Reverse Side)

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 Jack Hacept

Licensed Embalmer No. 4746

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.