

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44480
State File No. 11911
Registrar's No.

FILED JAN 5 1954

BIRTH NO. 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) a. STATE Missouri b. COUNTY Saline County	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Slater	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 7 Days.		e. STREET ADDRESS (If rural, give location) 0971	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Pacific Hospital.			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lonck</u> b. (Middle) <u>Edward</u> c. (Last) <u>Smock</u>			4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1953.		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 30, 1896.	9. AGE (In years last birthday) 57.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY G M&O R. R.	11. BIRTHPLACE (City and State or Foreign Country) Roodhouse, Illinois.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Charles Smock	13b. MOTHER'S MAIDEN NAME Ella Kaufman	14. NAME OF HUSBAND OR WIFE Bernice Smock
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. Nil.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernice Smock, Slater, Missouri.

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) <u>Coma, Hepatic</u> ANTECEDENT CAUSES <u>Laenne's Cerebrum</u> DUE TO (b) <u>Esophageal varix, bleeding</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u> <u>9 days</u>
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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? 5811

22. I hereby certify that I attended the deceased from Dec 11, 1953, to Dec 17, 1953, that I last saw the deceased alive on Dec 16, 1953, and that death occurred at 5:15 AM, from the causes and on the date stated above.

23a. SIGNATURE <u>Clarence J. Culleray M.D.</u> (Degree or title)	23b. ADDRESS <u>710 S. Poe Hosp. Bldg.</u>	23c. DATE SIGNED <u>12-17-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>12-17-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>
		24d. LOCATION (City, town, or county) (State) <u>Slater, Missouri.</u>

DATE REC'D BY LOCAL REG. REC 17 1953	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 5 1934

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 *J. W. Bumbley*.....
Licensed Embalmer No. *3653*.....

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.