

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	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St Louis 225 th	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 251406 Cole St	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer S Phillips			

3. NAME OF DECEASED (Type or Print) a. (First) IVY b. (Middle) SMITH c. (Last) SMITH		4. DATE OF DEATH (Month) (Day) (Year) 4 15 1954	
5. SEX Male	6. COLOR OR RACE negro	7. MARRIED. NEVER MARRIED. WIDOWED. DIVORCED (Specify) married	8. DATE OF BIRTH 12/25/1901
9. AGE (In years last birthday) 52		10. KIND OF BUSINESS OR INDUSTRY LABORER	11. BIRTHPLACE (State or foreign country) Nashville Tenn
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John Smith		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Magnolia Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs Senia Baree 10067 14 th	

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Lobar Pneumonia, left.</u> 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		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 490 X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE Patrick J. Taylor, Coroner		(Degree or title)		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 4. 19. 54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/20/54		24c. NAME OF CEMETERY OR CREMATORY Douglas East Forest		24d. LOCATION (City, town, or county) (State) Ill	
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DATE REC'D BY LOCAL REG. APR 19 1954		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Clarence Houston		ADDRESS 812 Thomas	
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed Leroy W. Dammister

Signed.....
Student Embalmer

Licensed Embalmer No. 4523

P. O. Address 3880 E. Peterson

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.