

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17306

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4189**

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 OR TOWN St. Louis Missouri)		c. LENGTH OF STAY (in this place) 3 weeks		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) 226 3508 No. 9th, Street Rear			
3. NAME OF DECEASED (Type or Print) a. (First) Charles		b. (Middle)		c. (Last) Smock	
4. DATE OF DEATH May 10 1954		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH August 30, 1870		9. AGE (In years last birthday) 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Nathinal Smock		13b. MOTHER'S MAIDEN NAME Martha Horstman	
14. NAME OF HUSBAND OR WIFE Mary Smock		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT'S SIGNATURE OR NAME Mary Smock, 3508 North 9th, Street Rear		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) Lobar pneumonia ANTECEDENT CAUSES DUE TO (b) atelectasis, RML. DUE TO (c) chronic bronchitis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Urinary tract infection	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 490X	
22. I hereby certify that I attended the deceased from 4-19-54 , 19___, to 5-10-54 , 19___, that I last saw the deceased alive on 5-10-54 , 19___, and that death occurred at 6145th from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Robert F. Owen, M.D.		23b. ADDRESS 1515 Lafayette		23c. DATE SIGNED 5-16-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 11th 1954		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.,		DATE REC'D BY LOCAL REG. MAY 10 1954		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leidner Und. Co. 2223 St. Louis Ave.,	

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, Student Embalmer No..... working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed..... *Robert M. Murray*

Licensed Embalmer No..... *3749*

P. O. Address..... *St. Louis*

**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.**