

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

39251

9470

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>ST. LOUIS</b> )		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>20 220 2624A St. Louis Ave.,</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>OSCAR SMITH</b>		b. (Middle) _____		c. (Last) <b>SMITH</b>	
4. DATE OF DEATH		(Month) <b>OCTOBER</b>		(Day) <b>18</b>		(Year) <b>1954</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Feb. 1-1886</b>	
9. AGE (In years last birthday) <b>68</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 10 YRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Box Maker</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Lacy, Ark.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John W. Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Lucinda Van Camp</b>		14. NAME OF HUSBAND OR WIFE <b>Helen Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>429-09-1979</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Helen Smith 2624A. St. Louis Ave.,</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL THROMBOSIS</b>  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.				INTERVAL BETWEEN ONSET AND DEATH	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>332X</b>			
22. I hereby certify that I attended the deceased from <b>10-12-54</b> , to <b>10-18-54</b> , that I last saw the deceased alive on <b>10-18-54</b> , and that death occurred at <b>7:45A</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>Paul W. Larson, M.D.</b> (Degree or title)				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>10-18-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Oct. 20th/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.,</b>	
DATE REC'D BY LOCAL REG. <b>OCT 19 1954</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Leidner Undertaking Co 2223 St. Louis Av.</b>			

WRITE PLAINLY—USING UNFADING 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, ~~on~~ by ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Etienne H. Penelup*.....

Licensed Embalmer No. *42*.....

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.