

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39613**

FILED DEC 13 1954

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 547		Registrar's No. 2771	
1. PLACE OF DEATH a. COUNTY Saint Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, give RURAL and give township) OR TOWN St. Mary's Hospital				c. CITY (Giveable corporate limits, write RURAL and give township) Saint Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital				d. STREET ADDRESS (If rural, give location) 4518 Laclède			
3. NAME OF DECEASED (Type or Print) LENA		a. (First) V		c. (Last) Smith		4. DATE OF DEATH (Month) (Day) (Year) Nov. 29 1954	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov 26 1889	
9. AGE (In years last birthday) 65		10. MONTHS 4		10. DAYS 20		10. HOURS 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Union City Tenn		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Joe Ross Powers		13b. MOTHER'S MAIDEN NAME Mary Tibbs		14. NAME OF HUSBAND OR WIFE Geo E Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 493-03-3142		17. INFORMANT'S SIGNATURE OR NAME Geo E Smith ADDRESS 4518 Laclède			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of left kidney				INTERVAL BETWEEN ONSET AND DEATH 7 mo.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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) 180X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from May 1954 to Nov 1954 , that I last saw the deceased alive on 11-29 1954 , and that death occurred at 9P m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) John J. Miller MD				23b. ADDRESS 8203 Chippewa		23c. DATE SIGNED 11-31-54	
24a. BURIAL, CREMATION, OR OTHER REMOVAL (Specify) Removal		24b. DATE Dec 1 1954		24c. NAME OF CEMETERY OR CREMATORY Castview Cemetery		24d. LOCATION (City, town, or county) (State) Union City Tenn	
DATE REC'D BY LOCAL REG. 12-1-54		REGISTRAR'S SIGNATURE Hubert R. Dombrowski		25. FUNERAL DIRECTOR'S SIGNATURE Center Mortuary ADDRESS 4209 Washington			

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 ME

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed G. W. Wilkinson

Licensed Embalmer No. 3575

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