

XC 483647
REG. 5835 SL-153

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.
5336

BIRTH NO. FILED AUG 2 - 1955 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY MADISON	
b. CITY OR TOWN 915 North Grand, St. Louis, Mo.		c. LENGTH OF STAY (in this place) 160 DAYS	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS (If rural, give location) Route No. 1	

3. NAME OF DECEASED (Type or Print) MIKE M. SMITH			4. DATE OF DEATH (Month) (Day) (Year) 6-19-1955		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH 10-19-90		9. AGE (In years last birthday) 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat Industry		11. BIRTHPLACE (City and State or Foreign Country) Washington, Ind.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME AMOS B. SMITH		13b. MOTHER'S MAIDEN NAME ANNISE LYNCH		14. NAME OF HUSBAND OR WIFE MINNIE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 348053460		17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, ST. LOUIS, MO.	

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.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHIAL PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) SQUAMOUS CARCINOMA OF RIGHT TONSILLAR PILLAR		18 MONTHS	
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 3-30-1955		19b. MAJOR FINDINGS OF OPERATION BIOPSY RIGHT PHARYNX - REPEAT REQUESTED			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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 145X		

22. I hereby certify that I attended the deceased from 1-10, 1955, to 6-19, 1955, and that death occurred at 11:10 a.m., from the causes and on the date stated above.

23a. SIGNATURE Miller MILER		(Degree or title) M.D.		23b. ADDRESS VAH, ST. LOUIS, MO.		23c. DATE SIGNED 6-19-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 22, 55		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope		24d. LOCATION (City, town, or county) (State) Belleville, Illinois	
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DATE REC'D BY LOCAL REG. JUN 20 1955		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE W. Hubert C. Rapp		ADDRESS Collinsville, Ill.	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that *not* the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by *Embalmed*, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Herbert C. Koss*.....

Licensed Embalmer No. *6890*

P. O. Address *Collinsville*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.