

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **38905**
Registrar's No. **10358**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) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 5 hours	c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital			e. STREET ADDRESS (If rural, give location) 5450 Beacon Avenue		
3. NAME OF DECEASED (Type or Print) Ruby			a. (First)	b. (Middle)	c. (Last) Smith
4. DATE OF DEATH (Month) (Day) (Year) Nov 27 1955					
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 29 1897	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (City and State or Foreign Country) Fayetteville, Arkansas	
12. CITIZEN OF WHAT COUNTRY? USA					
13a. FATHER'S NAME William R. Williams		13b. MOTHER'S MAIDEN NAME Georgia A. Morgan		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) NO		16. SOCIAL SECURITY NO. 441-16-9797		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Jacqueline Lusted, 5450 Beacon Ave	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)					
MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 4-6 hours	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.					
ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
DUE TO (b) Essential Hypertension					
DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death. Coronary Heart Disease					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION due to Coronary Thrombosis			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) 331X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 Jan 1952 , to Nov 27, 1955 , that I last saw the deceased alive on NOV 27, 1955 , and that death occurred at 6:30 pm. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) David Light D.O.			23b. ADDRESS 5738 W. Flourissant		23c. DATE SIGNED 11-28-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Nov 30 1955	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) Normandy, St. Louis Co., Missouri
DATE REC'D BY LOCAL REG. NOV 28 1955		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MATH HERMANN & SON, INC., 2161 E. Fair Ave	

(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 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 *Walter G. Burnley*

Licensed Embalmer No. *426*

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.