

FILED JAN 11 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42642

State File No. _____

BIRTH NO. 91477-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10944

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Afton 23 4820</u>		d. STREET ADDRESS (If rural, give location) <u>9310 Sterling</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>Saint Louis Maternity</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>December 9 1955</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Smith</u> b. (Middle) c. (Last)			5. SEX <u>Male</u>		
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>--</u>	8. DATE OF BIRTH <u>December 8 1955</u>		9. AGE (In years last birthday) <u>5</u> <u>Months</u> <u>Days</u> <u>5</u> <u>Mins.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	11. BIRTHPLACE (State or foreign country) <u>St Louis Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U</u>
13a. FATHER'S NAME <u>Clifford H Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara A Holstein</u>		14. NAME OF HUSBAND OR WIFE <u>--</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Barbara A Smith</u> ADDRESS <u>above</u>		
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) <u>Prematurity</u> INTERVAL BETWEEN ONSET AND DEATH <u>SHS 4:30min</u> ANTECEDENT CAUSES <u>Malnutrition</u> Morbidity conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <u>Malnutrition</u> DUE TO (c) <u>7725</u> 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 <u>7725</u>		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) m.
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>276x</u>			
22. I hereby certify that I attended the deceased from <u>Dec 8</u> , 1955, to <u>Dec 9</u> , 1955, that I last saw the deceased alive on <u>Dec 9</u> , 1955, and that death occurred at <u>1:00 A</u> m., from the causes and on the date stated above.					
23. SIGNATURE (Degree or title) <u>William Bernauer MD</u>			23b. ADDRESS <u>467 N. Taylor</u>		23c. DATE SIGNED <u>12/9/55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>12-31-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>DEC 14 1955</u>		REGISTRAR'S SIGNATURE <u>Charles Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Aker</u> ADDRESS <u>4104 Manchester</u>	

(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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed.....
Student Embalmer

Licensed Embalmer No.

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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