

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15104**

FILED APR 27 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **312** PRIMARY REG. DIST. NO. **590** Registrar's No. **901**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Wellston</b>	c. LENGTH OF STAY (In this place) <b>4 yrs</b>	c. CITY OR TOWN <b>Wellston 4201</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Snyder Nursing Home</b>		e. STREET ADDRESS (If rural, give location) <b>8615 Hume Avenue</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Emily</b> b. (Middle) _____ c. (Last) <b>Smith</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>4 - 2 - 1956</b>		
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5. SEX <b>Fem</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>3 - 4 - 11865</b>	9. AGE (In years last birthday) <b>91</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Michael McGuire</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine</b>	14. NAME OF HUSBAND OR WIFE <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown Smith</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Ione Snyder, 8615 Hume Ave.</b>	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>VIRUS PNEUMONIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 MO</b>
	ANTECEDENT CAUSES DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>removal atherosclerosis</b>		<b>20 YRS</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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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) <b>492X</b>
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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?
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22. I hereby certify that I attended the deceased from **3-5**, 19**56**, to **4-2**, 19**56**, that I last saw the deceased alive on **4-2**, 19**56**, and that death occurred at **9P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Dorothy O. Smith M.D.</b>	23b. ADDRESS <b>1194 Hock...</b>	23c. DATE SIGNED <b>4-3-56</b>
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24a. DATE <b>4/4/56</b>	24b. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	24c. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>4-3-56</b>	REGISTRAR'S SIGNATURE <b>Berbert R. Lombardi</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Drehmann-Harral 1905 Union Blvd.</b>
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

0.300  
0.48

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 *Albert R. Thompson*

Licensed Embalmer No. *42*

P. O. Address *H. J. ...*

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.