

FILED JUN 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH57 0 2 2 9 0 8
State File No.

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

5511

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 town) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 22 St. Anthony's Hospital		e. STREET ADDRESS (If rural, give location) 2031 8 5118 Jamieson Ave	
3. NAME OF DECEASED (Type or Print) a. (First) NELLIE b. (Middle) MAY c. (Last) SMITH		4. DATE OF DEATH (Month) (Day) (Year) 6-10-1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 3-15-1889
9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	11. BIRTHPLACE (City and State or Foreign Country) Missouri
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Louis Dreier		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Royd Taylor		ADDRESS 9604 Twin Crest Drive	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ATHEROSCLEROTIC HEART DISEASE WITH DECOMPENSATION INTERVAL BETWEEN ONSET AND DEATH UNK ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.0	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)		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 5-11-1957 , to 6-10-1957 , that I last saw the deceased alive on 6-10-1957 , and that death occurred at 7:30 P m. , from the causes and on the date stated above.			
23a. SIGNATURE Henry Cooper		(Degree or title) M.D.	
23b. ADDRESS 818 Olive St		23c. DATE SIGNED 6/14/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-13-1957	
24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		24d. LOCATION (City, town, or county) (State) 4260 Bates St Mo	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 13 57		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith M.D. Breckenridge	
ADDRESS m & B.		ADDRESS 6409 Gravois Ave	

(Licensed Embalmer's Statement on Reverse Side)

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

CH 4-4747

11 till 3

No. 300
10. 48

STATE OF OHIO
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH
 STATE OF OHIO
 BUREAU OF HEALTH
 COLUMBUS, OHIO
 FORM NO. 1-3
 REV. 1-1-3
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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..... *Paul M. Seymour*
 Licensed Embalmer No. 434
 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.

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