

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 6 1958

3617
STATE FILE NUMBER
991

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
-57

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MADISON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FIRMIN DESLOGE		Length of stay in lb 28 days	d. STREET ADDRESS (If outside, give location) 32 940 GREENWOOD ST		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HELEN L SMITH			4. DATE OF DEATH Month Day Year JAN 24 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 19 1929	9. AGE (In years last birthday) 28	IF FUNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE TRAINING		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) EAST ST LOUIS Ill		12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME WILLIAM D BURKETT		13b. MOTHER'S MAIDEN NAME IRENE JOHNSTON		14. NAME OF HUSBAND OR WIFE THOMAS SMITH	
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.	17. INFORMANT Address Thomas W. Smith 940 Greenwood Ave Madison Ill		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute Stenosis</u> DUE TO (c) <u>Rheumatic Fever</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>411X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>Indefinite</u> <u>21 yrs.</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>12/31/57</u> to <u>1/24/58</u> and last saw her alive on <u>1/24/58</u> Death occurred at <u>3:39 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>C. Rollins Haulon M.D.</u> (Degree or title)			22b. ADDRESS 1325 S. Grand St. Louis, Mo.		22c. DATE SIGNED 1/25/58
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
REMOVAL		1-27-58			E ST LOUIS, ILLINOIS 58
24. FUNERAL DIRECTOR ADDRESS ROBINS FUNERAL HOME E ST LOUIS, Ill.			25. DATE RECD. BY LOCAL REG. JAN 27 58		26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Lawyer, etc. must use only standard nomenclature. All diseases in Part I must be causally related.

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 *Frank Prokop*

Licensed Embalmer No. *4356*

P. O. Address *St. Louis Mo*

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.