

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024108

STATE FILE NUMBER

FILED JUL 11 1958 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1576

1. PLACE OF DEATH a. COUNTY <u>HOME ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkloch MO.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kirkloch 40910</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1020 Schoolway</u>			Length of stay in lb <u>YRS</u>		d. STREET ADDRESS (If/outside, give location) <u>1020 Schoolway</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle _____ Last <u>SMITH</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>10</u> Year <u>1958</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 6, 1895</u>		9. AGE (In years last birthday) <u>63</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAULMAN PORTER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>JACKSON MISS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>CHARLIE SMITH</u>				14. MOTHER'S MAIDEN NAME <u>LUKA SMITH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u>			16. SOCIAL SECURITY NO. <u>709-12-4173</u>		17. INFORMANT <u>William Smith</u>			Address _____	
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>Cancer of the Throat</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1yr</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<u>148X</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 _____ a. m. _____ p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20e. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21. I attended the deceased from <u>Feb 19 57</u> to <u>June 10, 1958</u> and last saw <u>him</u> alive on <u>June 10, 1958</u> . Death occurred at <u>7:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>J. D. Howard M.D.</u>				22b. ADDRESS <u>1110 Hugo Kirkloch Mo</u>		22c. DATE SIGNED <u>6-11-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JUNE 16 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON PARK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BERKELY MO</u>			
24. FUNERAL DIRECTOR <u>CHARLIE WOODLEY</u>			ADDRESS <u>2829 WASHINGTON</u>		25. DATE RECD. BY LOCAL REG. <u>6-13-58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Drake M.D.</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare Public Service
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 *Edward A. Flynn*

Licensed Embalmer No. *449*

P. O. Address *4202 Fe*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.