

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035039  
STATE FILE NUMBER

REG OCT 6 1958 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2504

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEBSTER GROVES</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Page Dale</b> <b>4000</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Glenwood Clinics</b> Length of stay in 1b <b>16 days</b>		d. STREET ADDRESS (If outside, give location) <b>6731 KOBINS</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>Gale</b> Last <b>Smith Jr.</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>28</b> Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/29/01</b>
9. AGE (In years - last birthday) <b>57</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher in Telegraph School</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway</b>	11. BIRTHPLACE (City and state or country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>Claude Smith</b>	
13b. MOTHER'S MAIDEN NAME <b>Sadie Smith</b>		14. NAME OF HUSBAND OR WIFE <b>Leola Smith</b>	
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>198-05-8928</b>	
17. INFORMANT <b>Wife</b> <b>Leola Smith</b> Address <b>6731 KOBINS</b>		18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>CORONARY ARTERIO SCLEROSIS</b> DUE TO (c) <b>4201</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>BRONCHOPNEUMONIA</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>		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 <b>12:00</b> Month <b>SEP</b> Day <b>28</b> Year <b>1958</b> a.m. <b>0</b> p.m. <b>0</b>		20d. INJURY OCCURRED WHILE AT WORK <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 <b>SEP 12, 1958</b> to <b>SEP 28, 1958</b> and last saw <sup>her</sup> him alive on <b>SEP 27, 1958</b> Death occurred at <b>4135th</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Thomas T. Flynn MD</b> (Degree or title) <b>0</b>		22b. ADDRESS <b>300 Scott Rd</b>	
22c. DATE SIGNED <b>9/29/58</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>Oct 1, 1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKE CHARLES Memorial Park Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		24. FUNERAL DIRECTOR ADDRESS <b>Shepard Funeral Home 1167 Hamilton Ave</b>	
25. DATE RECD. BY LOCAL REG. <b>9-29-58</b>		26. REGISTRAR'S SIGNATURE <b>Herbert P. Danke M.D.</b>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J Wm E Embler* .....

Licensed Embalmer No. *3253* .....

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.