

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046336
STATE FILE NUMBER
12593
Registrar's No.

FILED JAN 12 1958 Administration District No. 318 Primary Registration District No. 1003

300
1-57

1. PLACE OF DEATH a. COUNTY		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. 6, 1896		9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis		13a. FATHER'S NAME Robert Taylor		13b. MOTHER'S MAIDEN NAME Margaret Burns		14. NAME OF HUSBAND OR WIFE Will 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. None		17. INFORMANT Mr. Will Smith, 6108 North Pointe		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE Sudden massive coronary occlusion Cardiac fibrillation Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260x		INTERVAL BETWEEN ONSET AND DEATH 2 hrs chronic chronic			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6108 North Pointe		Length of stay in lb 2 Mo.		d. STREET ADDRESS (If outside, give location) 6108 North Pointe		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		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 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 Death occurred at 11-9-58 to 12-26-58 10:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE E. J. Laische, M.D.		(Degree or title)		22b. ADDRESS 6303 Natural Bridge		22c. DATE SIGNED 12-29-58		23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 12/30/58		23c. NAME OF CEMETERY OR CREMATORY St. Ferdinand		23d. LOCATION (City, town, or county) (State) Florissant Mo.					
24. FUNERAL DIRECTOR Drehmann-Harral 1905 Union Blvd.		ADDRESS		25. DATE RECD. BY LOCAL REG. DEC 29 '58		26. REGISTRAR'S SIGNATURE Carl Smith															

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

Dr. E. A. Lansche
6303 Natural Bridge
E.V. 5-9393
Hrs. 10-12:30 Mon.

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. *4257*

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.