

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046604

STATE FILE NUMBER

FILED JAN 6 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3280

1. PLACE OF DEATH a. COUNTY Saint Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN Kinloch 4000	
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital		d. STREET ADDRESS 58 Carson	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb DOA		Reside on Farm Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) E M A N U E L S M I T H			4. DATE OF DEATH December 12, 1958		
First Middle Last			Month Day Year		

5. SEX Male 2	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Dec 1893	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	10b. KIND OF BUSINESS OR INDUSTRY Public School	11. BIRTHPLACE (City and state or country) Beulah, Miss	12. CITIZEN OF WHAT COUNTRY? US of A
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13. FATHER'S NAME Simon Smith	14. MOTHER'S MAIDEN NAME Belle Smith
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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. 709-09-5410	17. INFORMANT Mildred Smith, Kinloch, Mo.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown natural causes		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
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"/> 2

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.)
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20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 7:47A m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Herbert R. Domke	22b. ADDRESS 801 S. Brentwood Clayton, Mo.	22c. DATE SIGNED 12/19/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 15 Dec 58	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State). Berkeley, Mo.
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24. FUNERAL DIRECTOR Boyd Bros, Kinloch, Mo.	25. DATE RECD. BY LOCAL REG. 12-15-58	26. REGISTRAR'S SIGNATURE Herbert R. Domke MD
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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
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 47

P. O. Address St. Louis

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