Health, Welfare Public Service

300
1-57

26
34
0

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003515
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 345

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST.LOUIS CITY HOSP. — Length of stay in Ib #1	d. STREET ADDRESS (If outside, give location) 223 1813 S. 11th — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First CLAUDE	Middle	Last SMITH	4. DATE OF DEATH	Month 1/10/59 Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH 1-18-1892	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Unemployed	11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Green Smith	13b. MOTHER'S MAIDEN NAME Minerva Gann	14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Bertha Schmitz, 3325 Ohio	Address		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac insufficiency

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Pulmonary edema

DUE TO (c) ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 42.22

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1/3/59, to 1/10/59 and last saw her/him alive on 1/10/59. Death occurred at 6:10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph J. Rabbitt M.D. (Degree or title)

22b. ADDRESS 1515 LAFAYETTE AVE.

22c. DATE SIGNED 1/10/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 1-13-59

23c. NAME OF CEMETERY OR CREMATORY New Pickers Cem.

23d. LOCATION (City, town, or county) St. Louis Co., (State) Missouri

24. FUNERAL DIRECTOR McLAUGHLIN'S, ADDRESS 2301 Lafayette

25. DATE RECD. BY LOCAL REG. JAN 12 '59

26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. 5550

P. O. Address .....

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.