

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007650

STATE FILE NUMBER

2 1864

FILED MAR 10 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Saint Louis,</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b	d. STREET ADDRESS <u>4118 St. Louis Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>DEMETRIA NMN SMITH</u>			4. DATE OF DEATH <u>FEBRUARY 19, 1959</u> Month Day Year		
5. SEX <u>Female</u> 3	6. COLOR OR RACE <u>Colored</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>2-28-1916</u> 42	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days <u>11 27</u> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Sid 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>		16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT Address <u>Charles Smith 2813 Stoddard St.</u>		
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>RECTOVAGINAL AND VESICOVAGINAL FISTULA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7-10 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. } DUE TO (b) <u>CARCINOMA OF CERVIX, LEAGUE OF NATIONS III</u>					<u>2 YEARS</u>
DUE TO (c) <u>171X</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 checked="" type="checkbox"/> NO <input type="checkbox"/> 1
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 o.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <u>JAN. 27, 1959</u> to <u>FEB. 19, 1959</u> and last saw her/him alive on <u>FEB. 19, 1959</u> Death occurred at <u>8:13 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>C. D. Vermillion, M.D.</u> (Degree or title) M. D.			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>2/19/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<u>Removal</u>		<u>2-23-59</u>	<u>Washington Park</u>		<u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Ellis Funeral Home 2820 Stoddard St.</u>			25. DATE RECD. BY LOCAL REG. <u>FEB 21 '59</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only standard nomenclature in their report. No symptoms written on form.  
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 *Fulton E. Culkin*

Licensed Embalmer No. *4198*  
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.