

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007657
STATE FILE NUMBER

FILED FEB 17 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 1193**

300
1-57
20
193
6

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4227 W. Aldine		d. STREET ADDRESS (If outside, give location) 4227 W. Aldine	
Length of stay in lb 5 Yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
Louis	C.	Smith	Feb.	1.	1959

5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1917	9. AGE (In years last birthday) 41	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) Mail Clerk	10b. KIND OF BUSINESS OR INDUSTRY Post Office	11. BIRTHPLACE (City and state or country) Fort Smith, Arkansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	---	---	---

13a. FATHER'S NAME Jake Smith	13b. MOTHER'S MAIDEN NAME Anna Criswell	14. NAME OF HUSBAND OR WIFE Mrs. Arezelle W. Smith
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II	16. SOCIAL SECURITY NO. 495-14-8914	17. INFORMANT Mrs. Arezelle W. Smith	Address 4227 W. Aldine
---	---	--	----------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Coronary Sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 420-1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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"/>

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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick Taylor Carson	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 2. 3. 59.
--	-----------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/6/59	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
---	----------------------------	--	---

24. FUNERAL DIRECTOR G. Wade Granberry	ADDRESS 4202 Finney Ave.,	25. DATE RECD. BY LOCAL REG. FEB 3 '59	26. REGISTRAR'S SIGNATURE Stan Smith, M.D.
--	-------------------------------------	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Docu, Coluiter, etc. must use oily standard nomenclature in item 18. No symptoms will be listed. 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 *Edward A. Flynn*

Licensed Embalmer No. 4444.....

P. O. Address 4202...Finney..Ave.

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.