

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011399  
STATE FILE NUMBER

FILED APR 14 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. 2927

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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.

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bonhomme Twsp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Bros Hosp</b>			Length of stay in lb <b>22 days</b>	d. STREET ADDRESS (If outside, give location) <b>Sulphur Springs Rd.</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Richard</b> Last <b>Smallbrook</b>				4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1959</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 6, 1897</b>		9. AGE (In years last birthday) <b>61</b>	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) <b>Plumber</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Kopf Plumbing Co</b>		11. BIRTHPLACE (City and state or country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>	
13a. FATHER'S NAME <b>Karl Wm. Smallbrook</b>			13b. MOTHER'S MAIDEN NAME <b>Theresa (Unk)</b>		14. NAME OF HUSBAND OR WIFE <b>Edith Smallbrook</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>498-10-7189</b>		17. INFORMANT Address <b>Edith Smallbrook Manchester Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b>						INTERVAL BETWEEN ONSET AND DEATH <b>over 3 months</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____								
DUE TO (c) <b>163X</b>								
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 <b>13 Feb. 1959</b> to <b>21 Mar. 1959</b> and last saw him alive on <b>21 Mar. 1959</b> Death occurred at <b>4:30</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Robert S. Nye, M.D.</b>				22b. ADDRESS <b>3201 Arsenal St., St. Louis Mo.</b>		22c. DATE SIGNED <b>23 Mar. 1959</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 24-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Schrader Funeral Home Ballwin Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>MAR 23 '59</b>		26. REGISTRAR'S SIGNATURE <b>Robert Smith, M.D.</b>		

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 ..... *Richard Bopp* .....

Licensed Embalmer No. *4584* .....

P. O. Address. *Baldwin, Mo* .....

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.