

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015745
STATE FILE NUMBER
2829

MAY 1 1959 Registration District No. Primary Registration District No. Registrar No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John Hosp.		d. STREET ADDRESS (If outside, give location) 431 S. Elm	
Length of stay in 1b 2 Weeks		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Daisy Smith			4. DATE OF DEATH Month Day Year 3/19/59			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1876	9. AGE (In years last birthday) 82	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ashley Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Thomas Sides		13b. MOTHER'S MAIDEN NAME Campbell	14. NAME OF HUSBAND OR WIFE James Smith			

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. None	17. INFORMANT Mrs. N. Garrison Centralia Ill.
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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) <u>Large Blood Abstraction due to</u> DUE TO (b) <u>Carcinoma of sigmoid associated with</u> DUE TO (c) <u>Diverterculitis of sigmoid colon</u>		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) 1533		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year 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
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21. I attended the deceased from March 6-59 to 3-18-59 and last saw her/him alive on 3-18-59
Death occurred at Lieo Ann on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>D. T. DeGree M.D.</u> (Degree or title)	22b. ADDRESS <u>634 N Grand Blvd</u>	22c. DATE SIGNED <u>3-19-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/19/59</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Centralia Ill.</u>
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24. FUNERAL DIRECTOR <u>Queen Boggs Centralia Ill.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAR 20 '59</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith. M.D.</u>
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S.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-57
5
4
0

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 *Flarence M. Billo*

Licensed Embalmer No. *4375*
P. O. Address *St. Louis 23 910*

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.