

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015748

STATE FILE NUMBER

23859

FILED MAY 15 1959

Registration District No. Primary Registration District No. Registrar No. 3859

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN Glasgow Village | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hosp. | | d. STREET ADDRESS (If outside, give location) 421 Shepley | |
| 3. NAME OF DECEASED (Type or print) First GENA Middle RUTH Last SMITH | | 4. DATE OF DEATH April 19, 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 26, 1956 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | 9. AGE (In years last birthday) 3 |
| 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME Perry J. Smith | | 13b. MOTHER'S MAIDEN NAME Mildred Sommer Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Perry J. Smith, 421 Shepley | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Barbiturate Intoxication</i> | | | INTERVAL BETWEEN ONSET AND DEATH 871.0/4 |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input checked="" 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.) <i>Self ingested in house on ac</i> | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. 4:18 p.m. 1959 p.m. about April 18, 1959. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, store, office bldg, etc.) 35 Home | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Mo. | |
| 21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>Satrick Taylor Coover</i> | | 22b. ADDRESS 1300 Clark | |
| 22c. DATE SIGNED 4-20-59 | | 22d. (Degree or title) 3 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE April 20, 1959 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery | | 23d. LOCATION (City, town, or county) (State) Coffeen, Illinois | |
| 24. FUNERAL DIRECTOR Stock Mortuary, 2117 E. Grand Bl. | | 25. DATE RECD. BY LOCAL REG. APR 20 '59 | |
| 26. REGISTRAR'S SIGNATURE <i>Lead Smith, M.D.</i> | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Paul A. Wachtel*

Licensed Embalmer No. *4787*
P. O. Address *St. Louis 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.