

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020032

STATE FILE NUMBER

FILED JUN 2 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1340

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451
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1. PLACE OF DEATH a. COUNTY St. Louis		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 Gardenville		c. CITY OR TOWN St. Louis	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Miller Nursing Home 8149 Gravois		d. STREET ADDRESS (If outside, give location) 3614a Pennsylvania Ave.	
3. NAME OF DECEASED (Type or print) First CAROLINE Middle DOLL Last SMITH		4. DATE OF DEATH Month May Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1889
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, if any, if retired) Clerk (Retired) Graham Paper Co.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Frank Doll		13b. MOTHER'S MAIDEN NAME Caroline Meyer	14. NAME OF HUSBAND OR WIFE Late Edward K. 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. 494-07-8783	17. INFORMANT Address Mignonette Brenner 3820 Utah St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, right side Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic Arteriosclerosis DUE TO (c) 331x			INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr.
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 WORK <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 April 23, 1959 to May 13th '59 and last saw her alive on May 12, 1959 Death occurred at 7:00 P. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. H. Walters M.D.		22b. ADDRESS 3608 S. Grand Blvd.,	22c. DATE SIGNED 5/15/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 18, 1959	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. 5-15-59	26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Richard W. Stovsand*

Licensed Embalmer No. *4007*

P. O. Address

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.