

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023406

STATE FILE NUMBER

2 6054

FILED JUL 7 1959

Registration District No. _____ Primary Registration District No. _____

Registration No. _____

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u> </u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CHRISTIAN Hosp.</u>		Length of stay in lb <u>9 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>1185 HODIAMONT</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY PATRICK SMITH</u>			4. DATE OF DEATH Month Day Year <u>JUNE 25, 1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 10, 1881</u>	9. AGE (In years last birthday) <u>77</u>	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) <u>AUDITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ST. LOUIS SYMPHONY</u>	11. BIRTHPLACE (City and state or country) <u>PHILADELPHIA, PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>GEORGE SMITH</u>		13b. MOTHER'S MAIDEN NAME <u>THERESA</u>		14. NAME OF HUSBAND OR WIFE <u>STELLA SMITH.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>489-20-9224</u>	17. INFORMANT Address <u>STELLA SMITH, 1185 HODIAMONT, ST LOUIS MO</u>		
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>Cerebral hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Generalized arteriosclerosis</u>					
DUE TO (c) <u>331x</u>					
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 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
21. I attended the deceased from <u>6-16-59</u> to <u>6-25-59</u> and last saw her/him alive on <u>6-24-59</u> Death occurred at <u>12:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>H. Klein</u>			22b. ADDRESS <u>5074 N. Union Blvd.</u>		22c. DATE SIGNED <u>6-26-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>6-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA</u>		23d. LOCATION (City, town, or county) (State) <u>ST LOUIS COUNTY, MO.</u>	
24. FUNERAL DIRECTOR <u>THE FLORISSANT MORTUARY,</u>		ADDRESS <u>Florissant Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 26 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

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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 *Gene Hutchinson*

Licensed Embalmer No. *4966*

P. O. Address *Housatonic, 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.