

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023408

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **5709**

FILED JUL 1 1959

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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
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Cleveland Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Inf. Length of stay in lb 3 Wks.		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James D. Smith			4. DATE OF DEATH Month Day Year June 13, 1959
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1871
9. AGE (In years of birthday) IF UNDER 1 YEAR Months Days Hours Min. 88		9. AGE (In years of birthday) IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Amanda 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 Address Mrs. Mae Layne #2 Lewis Place
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOWER NEPHRON NEPHROSIS, PD.			INTERVAL BETWEEN ONSET AND DEATH 12 Hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) SUBTOTAL GASTRECTOMY			24 HRS.
DUE TO (c) CARCINOMA OF STOMACH			1 YR.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151X			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 a.m. Month, Day, Year 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 JUNE 6, 1959 to JUNE 13, 1959 and last saw him live on 6-13-59 Death occurred at 6-13-59 9:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James M. Williams, M.D.		22b. ADDRESS 916 A. W. TAYLOR	22c. DATE SIGNED 6-15-59
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 6-16-59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Dayton, Ohio
24. FUNERAL DIRECTOR ADDRESS Geo. W. Bruce 4469 Washington		25. DATE RECD. BY LOCAL REG. JUN 16 '59	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

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 *Frederick P. Stark*

Licensed Embalmer No. *4599*
P. O. Address *St. Louis*

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.