

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 4 1959

59-027224

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 6916** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2510 a W Palm St;</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>2510 a W Palm</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <p style="text-align: center;"><b>Christopher J Smith Jr.</b></p>			<b>4. DATE OF DEATH</b> Month Day Year <p style="text-align: center;"><b>7 24 59</b></p>				
<b>5. SEX</b> <p style="text-align: center;"><b>M</b></p>	<b>6. COLOR OR RACE</b> <p style="text-align: center;"><b>W</b></p>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <p style="text-align: center;"><b>Sept 10/03 55</b></p>	<b>9. AGE</b> (last birthday) <p style="text-align: center;"><b>55</b></p>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <p style="text-align: center;"><b>Watchman</b></p>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <p style="text-align: center;"><b>Dennis Chemical</b></p>		<b>11. BIRTHPLACE</b> (City and state or country) <p style="text-align: center;"><b>St. Louis</b></p>		<b>12. CITIZEN OF WHAT COUNTRY</b> <p style="text-align: center;"><b>U.S.A.</b></p>	
<b>13a. FATHER'S NAME</b> <p style="text-align: center;"><b>Christopher J. Smith Sr.</b></p>		<b>13b. MOTHER'S MAIDEN NAME</b> <p style="text-align: center;"><b>Kathryn Finnigan</b></p>		<b>14. NAME OF HUSBAND OR WIFE</b> <p style="text-align: center;"><b>Minnie Smith</b></p>			

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <p style="text-align: center;"><b>No.</b></p>	<b>16. SOCIAL SECURITY NO.</b> <p style="text-align: center;"><b>496-22-1460</b></p>	<b>17. INFORMANT</b> Address <p style="text-align: center;"><b>Minnie Smith 2510 a W. Palm St.</b></p>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial thrombosis</u> DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) <u>ASHD.</u>		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <p style="text-align: center;"><b>420.0</b></p>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year a.m. p.m.		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	

<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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**21. I attended the deceased from** March 20, 1959 to July 24, 1959 and last saw him alive on July 24, 1959  
**Death occurred at** July 24, 1959-2:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <p style="text-align: center;"><i>J. K. Kopeck</i> M.D.</p>	<b>22b. ADDRESS</b> <p style="text-align: center;"><u>3718 Grand Blvd</u></p>	<b>22c. DATE SIGNED</b> <p style="text-align: center;"><u>7/25/59</u></p>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <p style="text-align: center;"><b>Burial</b></p>	<b>23b. DATE</b> <p style="text-align: center;"><b>7/27/59</b></p>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <p style="text-align: center;"><b>Calvary Cemetery</b></p>	<b>23d. LOCATION</b> (City, town, or county) (State) <p style="text-align: center;"><b>St. Louis Mo.</b></p>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <p style="text-align: center;"><b>Robert D. Kinealy 2228 St. Louis Ave.</b></p>	<b>25. DATE RECD. BY LOCAL REG.</b> <p style="text-align: center;"><b>JUL 25 59</b></p>	<b>26. REGISTRAR'S SIGNATURE</b> <p style="text-align: center;"><i>Loan Smith, M.D.</i></p>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W E Morris

Licensed Embalmer No. 336

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.