

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

2 7793

59-030811

FILED VS SEP 11 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

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>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>3 hrs.</u>		c. CITY OR TOWN <u>Ferguson</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DePaul</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>221 Anastasia Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Katharine</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1959</u>					
5. SEX <u>Female</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>6-1-94</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (City and state or country) <u>Chicago, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>		
13a. FATHER'S NAME <u>James Keigher</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret White</u>			14. NAME OF HUSBAND OR WIFE <u>William M. 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>499-26-3805</u>		17. INFORMANT <u>William M. Smith</u>			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) <u>Acute cardiac decompensation with heart block 3:1</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic cardiovascular disease with hypertension &</u>							DUE TO (c) <u>auricular fibrillation</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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. _____ p.m. Month, Day, Year _____		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 <u>7/16/58</u> to <u>8/21/59</u> and last saw her <u>him</u> alive on <u>7/21/59</u> Death occurred at <u>1:30 am 7/21/59</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Frank S. Gray M.D.</u>				22b. ADDRESS <u>111 Cherokee Ferguson 35, Mo</u>			22c. DATE SIGNED <u>7/22/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>			23d. LOCATION (City, town, or county) <u>Florissant, Mo.</u>			(State)	
24. FUNERAL DIRECTOR <u>White-Mullen Mortuary, Ferguson,</u>				25. DATE RECD. BY LOCAL REG. <u>AUG 2 1959</u>		26. REGISTRAR'S SIGNATURE <u>Frank Smith M.D.</u>			

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 VE Morris

Licensed Embalmer No. 330

P. O. Address St Louis

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