

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS AUG 27 1959

2 7568 59-030815
 REGISTRATION DISTRICT NO. _____ PRIMARY REGISTRATION DISTRICT NO. _____ REGISTRAR'S NO. _____ STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis (15)</i>		Length of stay in 1b		c. CITY OR TOWN <i>St. Louis (7)</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Christian Hospital.</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>4239 E Grand</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>-</i> Last <i>Smoot</i>				4. DATE OF DEATH Month <i>8-</i> Day <i>14-</i> Year <i>1959-</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>w.</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>8-14-59</i>	9. AGE (last birthday) <i>3</i> Months <i>45</i> Days	IF UNDER 1 YEAR IF UNDER 24 HR Hours <i>3</i> Min. <i>45</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Packer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Calif. Mfg. Co.</i>		11. BIRTHPLACE (City and state or country) <i>St. Louis Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13a. FATHER'S NAME <i>Raymond Gerald Smoot</i>			13b. MOTHER'S MAIDEN NAME <i>Nancy Ruth Ballard</i>			14. NAME OF HUSBAND OR WIFE <i>-</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Nancy Smoot</i>		Address <i>4239 E Grand</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO (b) <i>premature labor</i> DUE TO (c) <i>776X</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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 <i>8-14-59</i> to <i>8-14-59</i> and last saw her ^{her} alive on <i>8-14-59</i> Death occurred at <i>2:15 P.M. 8-14-59</i> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Kenneth Larsen M.D.</i>				22b. ADDRESS <i>607 N. Grand</i>				22c. DATE SIGNED <i>8-14-59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>AUG. 17, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CALVARY CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS, MISSOURI</i>				
24. FUNERAL DIRECTOR <i>STOCK MORTUARY, 2117 E. GRAND BL.</i>				ADDRESS		25. DATE RECD. BY LOCAL REG. <i>AUG 15 '59</i>		26. REGISTRAR'S SIGNATURE <i>Head Smith. M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(H.T.)

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. *Not Embalmed*

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

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.