

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-034332

STATE FILE NUMBER

2 8181

FILED VS SEP 21 1959

Registration District No. Primary Registration District No. Registrar's No.

V. S. 300  
Rev. 1-56

31  
109

AD  
including

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. AD  
diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |                           |   |   |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis  |                           | c. CITY OR TOWN St. Louis   |   |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                           | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION State Hospital   |                           | d. STREET ADDRESS 4450a Labadie   |   |
| Length of stay in lb  |                           | (If outside, give location)<br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>ALFRED B. SMITH   |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>Aug. 31, 1959   |
| 5. SEX<br>Male <input checked="" type="checkbox"/>  | 6. COLOR OR RACE<br>Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br>7-11-30   |
| 9. AGE (In years last birthday)<br>29   |                           | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Unknown  | 11. BIRTHPLACE (City and state or country)<br>Greenwood, Miss.                                    |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S. A.   |                           | 13. FATHER'S NAME<br>Allen Smith  |   |
| 14. MOTHER'S MAIDEN NAME<br>Virlee Williams   |                           | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>Yes Korean War                                 |   |
| 16. SOCIAL SECURITY NO.<br>Unknown  |                           | 17. INFORMANT Address<br>Mrs. Virlee Smith, 4450a Labadie   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac arrest, while undergoing electro shock therapy treatment at State Hospital on Aug. 31, 1959. Accidental</i>         |                           |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <i>electro shock therapy treatment at State Hospital on Aug. 31, 1959. Accidental</i><br>DUE TO (c) <i>State Hospital on Aug. 31, 1959. Accidental</i> |                           |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>309XK</i>   |                           |   |   |
| 20a. ACCIDENT <input checked="" 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.)<br><i>See above</i>  |   |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.<br><i>8-31-59</i>   |                           | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><i>131 hospital</i>  |   |
| 20e. CITY, TOWN, OR LOCATION<br><i>St. Louis</i>  |                           | 20f. COUNTY STATE<br><i>Mo.</i>   |   |
| 21. I attended the deceased from _____ to _____ and last saw her alive on _____<br>Death occurred at <i>9:20 a. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.   |                           |   |   |
| 22a. SIGNATURE<br><i>Dorothy Taylor Carauer</i>   |                           | 22b. ADDRESS<br><i>1300 Clark</i>   |   |
| 22c. DATE SIGNED<br><i>9.3.59</i>   |                           | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal  |   |
| 23b. DATE<br><i>9-5-59</i>  |                           | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Washington Park Cem.</i>   |   |
| 23d. LOCATION (City, town, or county)<br><i>St. Louis County, Mo.</i>   |                           | 24. FUNERAL DIRECTOR ADDRESS<br><i>W.P. Richardson 2625 Glasgow Ave</i>   |   |
| 25. DATE RECD. BY LOCAL REG.<br><i>SEP 3 1959</i>   |                           | 26. REGISTRAR'S SIGNATURE<br><i>Loan Smith, M.D.</i>  |   |

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 *A. D. Richardson*  
Licensed Embalmer No. *2928*

P. O. Address *City*

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.