URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1959

59-034339
STATE FILE NUMBER

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 8195

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Deaconess Hospital — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: St. Louis
c. CITY OR TOWN: Richmond Heights — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 7714 St. Albans — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: WADE — Middle: CLIFFORD — Last: SMITH
4. DATE OF DEATH: Month: September — Day: 2, — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Dec. 9, 1894
9. AGE (last birthday): 64
IF UNDER 1 YEAR: Months: 8. Days: 23
IF UNDER 24 HR: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintance Electrican
10b. KIND OF BUSINESS OR INDUSTRY: Union Electric
11. BIRTHPLACE (City and state or country): Shelbyville, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Curtiss Smith
13b. MOTHER'S MAIDEN NAME: Juliette Raines
14. NAME OF HUSBAND OR WIFE: Gladys Barnoske Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 493-05-3331
17. INFORMANT: Gladys Smith, Address: 7714 St. Albans

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — 7 years
DUE TO (c): 4201
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. --- ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.): None
20c. TIME OF INJURY: Hour a.m. p.m. --- Month, Day, Year ---
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1932, to Sept. 2, 1959 and last saw him alive on Sept. 2, 1959
Death occurred at 3:35 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title): M.D.
22b. ADDRESS: 19 E. Lockwood
22c. DATE SIGNED: 9/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Sept. 5, 1959
23c. NAME OF CEMETERY OR CREMATORY: Hiram Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR: Ambruster Mortuary, ADDRESS: 6633 Clayton Rd.
25. DATE RECD. BY LOCAL REG.: SEP 4 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MJB

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. 4788

P. O. Address St. Louis

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