

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042531

FILED VS. NOV 16 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 9321** STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>Rock Hill</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>		d. STREET ADDRESS (If outside, give location) <b>1102 Rockman Pl.</b>	

3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Parnell</b> Last <b>Smith</b>	4. DATE OF DEATH Month <b>10</b> Day <b>10</b> Year <b>59</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 28, 1872</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>12</b>	IF UNDER 24 HR Hours <b>12</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Photo Engraver</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Photography</b>	11. BIRTHPLACE (City and state or country) <b>Owassa, Michigan</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Newcomb Spalding Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Jane Parnell</b>	14. NAME OF HUSBAND OR WIFE <b>Lillian Smith</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>489-07-7293</b>	17. INFORMANT <b>Elmer G. Smith, 1102 Rockman Pl.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Irreversible shock</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Septicemia with generalized sepsis</b>	INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Intertrochanteric Fracture of hip</b>	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.) <b>Fell from Chair at Little States of Mo</b>
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20c. TIME OF INJURY Hour <b>3:30</b> a.m. <b>10-7-1959</b> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <b>Little States of Mo</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo.</b>
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21. I attended the deceased from <b>10-7-59</b> to <b>10-10-59</b> and last saw him alive on <b>10-10-59</b> Death occurred at <b>2:35P</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>John J. O'Brien M.D.</b>	22b. ADDRESS <b>1515 Lafayette Ave.</b>	22c. DATE SIGNED <b>10-10-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Oct. 13, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
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24. FUNERAL DIRECTOR <b>Ambruster Mortuary, 6633 Clayton Rd.</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 13 1959</b>	26. REGISTRAR'S SIGNATURE <b>Elmer G. Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. J. O'Brien

**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

Licensed Embalmer No. 478

P. O. Address St. Louis

**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.