URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 0 1959

59-042534
STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210125

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1701 Pendelton
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: WILLIAM Middle: A. Last: SMITH
4. DATE OF DEATH: Month: NOVEMBER Day: 1 Year: 1959
5. SEX: Male
6. COLOR OR RACE: Col
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 27, Feb. '89
9. AGE (last birthday): 70
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): Pulman Porter
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (City and state or country): Knoxville Tenn
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: William Smith
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Della Mae Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mr Alferd Smith Address: 4925 Cote Brilliant

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ACUTE PULMONARY EDEMA	1-2 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	ARTERIOSCLEROTIC HEART DISEASE	15-20 YEARS
DUE TO (c)	420.0	

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.)
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 APRIL 30, 1936, to NOVEMBER 1, 1959 and last saw her/him alive on OCT. 31, 1959
Death occurred at 5:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE: Harold J. Joseph J. (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 11/3/59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11/6/59
23c. NAME OF CEMETERY OR CREMATORY: Greenwood
23d. LOCATION (City, town, or county) (State): St. Louis County Mo
24. FUNERAL DIRECTOR: Herman J. Smith ADDRESS: 4247 W Labadie
25. DATE RECD. BY LOCAL REG.: NOV 4 1959
26. REGISTRAR'S SIGNATURE: Roard Smith, M.D. M.D.B.

(Licensed Embalmer's Statement on Reverse Side)

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._____

P. O. Address_____

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