IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS FEB 23 1960

[redacted]

NDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1542 STATE FILE NUMBER 60-008894

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b: 32 yrs. 19 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis State Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St.Louis, Mo. — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 915 Aubert — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: ADA — Middle: — Last: SMITH

4. DATE OF DEATH: Month — Day — Year: Feb. 5, 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 7-8-1902

9. AGE (last birthday): 57 yrs.

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): formerly: stenographer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): St.Louis, Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Carter Smith

13b. MOTHER'S MAIDEN NAME: Ida (Chilcote)

14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ——

17. INFORMANT: Marie Rothwell — Address: 4140 Lindell Blvd.

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

IMMEDIATE CAUSE (a): Acute diffuse peritonitis, due to perforated duodenal ulcer

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 541.1

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):
Leiomyomata uteri

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 Jan. 17, 1938, to Feb. 5, 1960 and last saw her/him alive on Feb. 5, 1960
Death occurred at 7:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John H. McMahan, M.D. — John H. McMahan MD

22b. ADDRESS: 5400 Arsenal St.

22c. DATE SIGNED: 2-8-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 2-10-1960

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St.Louis,Mo.

24. FUNERAL DIRECTOR: Cullen-Kelly — ADDRESS: 7267 Natural Bridge

25. DATE RECD. BY LOCAL REG.: FEB 10 1960

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. E.P.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT — MEDICAL CERTIFICATION — BY AFFIDAVIT OF

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 Not Embalmed, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed James A. Lammers

Signature of Student Embalmer

Licensed Embalmer No. 4142

P. O. Address St. Louis

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