

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 12 1960

60-013233

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STATE FILE NUMBER

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

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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <i>St. Louis</i>                    |  | Length of stay in lb<br><i>10 Days</i>  | c. CITY OR TOWN <i>Woodson Terrace 34</i>                                |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <i>St. Lukes Hospital</i> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><i>9129 Kathryn Dr.</i> |
| Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                    |  |   |  |

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><i>Charles Crossley Smith</i>                       |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><i>March 23, 1960</i>           |  |   |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>11/19/90</i>                                   | 9. AGE (last birthday)<br><i>70</i>            | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Carpenter</i> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Retired 6 Years</i>   | 11. BIRTHPLACE (City and state or country)<br><i>Haywood, England</i> | 12. CITIZEN OF WHAT COUNTRY<br><i>U. S. A.</i> |   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 13a. FATHER'S NAME<br><i>Henry Smith</i>   |  | 13b. MOTHER'S MAIDEN NAME<br><i>Hanna Crossley</i> |  | 14. NAME OF HUSBAND OR WIFE<br><i>Ethnel Smith</i> |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>no none</i> |  | 16. SOCIAL SECURITY NO.<br><i>488-03-7846</i>      | 17. INFORMANT Address<br><i>Ethnel Smith, 9129 Kathryn Dr.</i> |  |  |

|  |   |  |               |
|--|---|--|---------------|
| 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>Uremia, Renal failure</i> |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 wk.</i> |               |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <i>General Atherosclerosis</i> |  | <i>4 yrs.</i> |
|  | DUE TO (c) <i>420.1</i>                   |  |               |

|   |  |  |  |
|---|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><i>Previous coronary and two strokes</i> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>Month, Day, Year   |  |  |  |

|  |  |                              |        |       |
|--|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 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 *Feb 2, 1954* to *March 23, 1960* and last saw him alive on *March 23, 1960*  
Death occurred at *11:58 p.m.* on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                   |   |   |                                    |
|---|-----------------------------------|---|---|------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><i>David Hulse Kerr, MD</i>                 |                                   | 22b. ADDRESS<br><i>950 Francis Pl. Clayton 5 Mo</i>               |   | 22c. DATE SIGNED<br><i>3-24-60</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Removal</i>                     | 23b. DATE<br><i>Mar. 26, 1960</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Lebanon Cemetery</i> | 23d. LOCATION (City, town, or county) (State)<br><i>St. Louis County, Mo.</i> |                                    |
| 24. FUNERAL DIRECTOR ADDRESS<br><i>Shepard Funeral Home, 1167 Hamilton (12)</i> |                                   | 25. DATE RECD. BY LOCAL REG.<br><i>MAR 25 1960</i>                | 26. REGISTRAR'S SIGNATURE<br><i>Robert Smith, M.D.</i>                        |                                    |

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

