

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS APR 12 1960**

**60-013239**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar **2. 3272**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>24 days</b>	c. CITY OR TOWN <del>St. Louis</del>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>4401 Carson Rd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Gordon</b> Middle <b>B.</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>3</b> Day <b>20</b> Year <b>60</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-6-86</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>William</b>		13b. MOTHER'S MAIDEN NAME <b>Ada ?</b>		14. NAME OF HUSBAND OR WIFE <b>Single</b>	
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>494-09-8453A</b>		17. INFORMANT Address <b>Schell L. Furry, 135 So. Rock Hill</b>	
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>Virus Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>492+</b>					
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 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 <b>2-24-60</b> to <b>3-20-60</b> and last saw him alive on <b>3-20-60</b> Death occurred at <b>8:15 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>			22b. ADDRESS <b>5800 Arsenal</b>		22c. DATE SIGNED <b>3/21/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-23-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>Parker-Aldrich-Webster Groves, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 22 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <i>mjs</i>	

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Lucie Walsh*

Licensed Embalmer No. *4393*

P. O. Address *Walter St*

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.