

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 12 1960

160-013245

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3660**

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 53 y-5 | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | | | d. STREET ADDRESS (If outside, give location) 3331a Delmar | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Samuel Middle Last Smith | | | | 4. DATE OF DEATH Month 3 Day 28 Year 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6-11-1906 | 9. AGE (last birthday) 53 | IF UNDER 1 YEAR Months 9 Days 17 | IF UNDER 24 HR Hours 17 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 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 Leander Smith | | | | |
| 13b. MOTHER'S MAIDEN NAME Aurfrances Spraglin | | | 14. NAME OF HUSBAND OR WIFE Lorraine Smith | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 495 6 09 - 190 | | 17. INFORMANT Lorraine Smith 3331 Delmar 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) Hypertensive Cardiovascular Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH Undet. | |
| DUE TO (b) _____ | | | | | | | |
| DUE TO (c) _____ 443X | | | | | | | |
| 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 type="checkbox"/> NO <input checked="" 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 3-18-60 to 3-28-60 and last saw him alive on 3-28-60 | | Death occurred at 5:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) [Signature] | | 22b. ADDRESS 2601 N. Whittier St. | | 22c. DATE SIGNED 3-28-60 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 4-2-1960 | 23c. NAME OF CEMETERY OR CREMATORY Father Dickson | 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. | | | | |
| 24. FUNERAL DIRECTOR J. H. RANDLE & SON 3133 Bell Ave. | | 25. DATE RECD. BY LOCAL REG. MAR 31 1960 | 26. REGISTRAR'S SIGNATURE [Signature] | | | | |

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 Esther H. Warren

Licensed Embalmer No. 445

P. O. Address 4181 Vas

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