

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021540

FILED VS JUN 9 1960

318

Primary Registration District No.

1003

Registrar's No.

5667

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BAKES HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5722 Maple</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>AMOS</b> Middle <b>NMN</b> Last <b>SMART</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>30</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/18/1909</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>West Green Ala</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
13a. FATHER'S NAME <b>Sam Smart</b>			13b. MOTHER'S MAIDEN NAME <b>Pearl Archibald</b>			14. NAME OF HUSBAND OR WIFE <b>Sarah Smart</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>488-18-3529</b>		17. INFORMANT <b>Sarah Smart</b> Address <b>5722 Maple</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>METASTATIC CARCINOMA WITH PLEURAL EFFUSION, PRIMARY LIVER SUSPECTED</b> DUE TO (b) _____ DUE TO (c) <b>155.0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)						INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</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 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 Month, Day, Year a.m. p.m.							
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>MAY 12, 1960</b> to <b>MAY 30, 1960</b> and last saw her/him alive on <b>MAY 30, 1960</b> Death occurred at <b>3:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>C.D. Vermillion, M.D.</i> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>BARNES HOSPITAL</b>			22c. DATE SIGNED <b>5/31/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>6/3/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Wood</b>		23d. LOCATION (City, town, or county) <b>6571 St. Louis Mo</b>			(State)
24. FUNERAL DIRECTOR <b>Whitney Funeral Home 3882 Delmar</b>			25. DATE RECD. BY LOCAL REG. <b>JUN 1 1960</b>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

moe.

JANUARY 1940

**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 F. A. Sheer

Licensed Embalmer No. 2963

P. O. Address 4214 S. 1st

JANUARY 1940

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.