

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021556

FILED VS MAY 25 1960

318

1003

5008

STATE FILE NUMBER

| | | | | | | |
|---|---|---|---|--|---|--|
| Registration District No. _____ | | Primary Registration District No. <u>1003</u> | | Registrar's No. <u>5008</u> | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b _____ | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>4011 Page</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Edward</u> Last <u>Smith</u> | | | 4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>60</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-19-60</u> | 9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days <u>9</u> IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and state or country) <u>Saint Louis, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME _____ | | 13b. MOTHER'S MAIDEN NAME <u>Marie Smith</u> | | 14. NAME OF HUSBAND OR WIFE _____ | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT <u>Hospital Record</u> | | Address <u>2601 N. Whittier</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth, Neonatal death</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | <u>7735</u> | |
| 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 <u>4-19-60</u> to <u>4-29-60</u> | | COUNTY _____ STATE _____ | | |
| 21. I attended the deceased from _____ and last saw him alive on <u>4-29-60</u> Death occurred at: <u>8:29x60 7:30 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE <u>Rach J. [Signature]</u> (Degree or title) <u>M. D.</u> | | | 22b. ADDRESS <u>2601 N. Whittier</u> | | 22c. DATE SIGNED <u>5-3-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) _____ | DATE <u>MAY 31 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | | |
| 24. FUNERAL DIRECTOR <u>Rowland Mortuary Svc.</u> ADDRESS <u>4104-06 Manchester</u> | | 25. DATE RECD. BY LOCAL REG. <u>MAY 12 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Ed Smith, M.D.</u> | | |

DED

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.