

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024986

FILED VS JUL 1 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6386** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b		c. CITY OR TOWN ST. LOUIS, MO	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3148 RUTGER	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					

3. NAME OF DECEASED (Type or print) First BABY BOY SMITH Middle OTIS EDWARD Last SMITH			4. DATE OF DEATH Month JUNE Day 8 Year 1960		
--	--	--	---	--	--

5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/8/80	9. AGE (last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min. 9
-----------------------	----------------------------------	---	-----------------------------------	------------------------	---------------------------	------------------------	-------	---------------

10a. USUAL OCCUPATION (Give kind of work done in most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	--	--	--

13a. FATHER'S NAME JAMES SMITH	13b. MOTHER'S MAIDEN NAME BETTY WOODEN	14. NAME OF HUSBAND OR WIFE
--	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT ST. LOUIS CITY HOSP. #1.	Address
--	--------------------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ateletosis		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)	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input 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 **6/8/60** to **JUNE 8, 1960** and last saw her **JUNE 8, 1960** alive on **8P**
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE R. James Vaccarella, M.D.	Degree or title	22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 6/8/60
---	-----------------	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 6-30-60	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) St. Louis, Mo.	(State)
---	-----------------------------	---	--	---------

24. FUNERAL DIRECTOR Rowland Mortuary Svc. 4104-06 Manchester	ADDRESS	25. DATE RECD. BY LOCAL REG. JUN 23 1960	26. REGISTRAR'S SIGNATURE Ed Smith, M.D.
---	---------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY-AFFIDAVIT OF

m & B

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 do so 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.