

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 14 1960

60-032877

NDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8880 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b <u>5 Days</u>	c. CITY OR TOWN <u>University City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6827 Vernon</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE NMN SMITH</u>			4. DATE OF DEATH Month Day Year <u>SEPTEMBER 8 1960</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-1886</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman (Retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>COAL MINING</u>	11. BIRTHPLACE (City and state or country) <u>Perry Co. Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>
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13a. FATHER'S NAME <u>Charles Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Alice GARY</u>	14. NAME OF HUSBAND OR WIFE <u>Bertha</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>344-01-2563</u>	17. INFORMANT <u>Bertha Smith</u> Address <u>6827 Vernon</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>		<u>6 DAYS</u>
Conditions, if any, which gave rise to above cause - (a), stating the underlying cause last.	DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>	<u>UNKNOWN</u>
	DUE TO (c) <u>420.0</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 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.)
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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
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21. I attended the deceased from <u>SEPT. 3, 1960</u> to <u>SEPT. 8, 1960</u> and last saw her/him alive on <u>SEPT. 8, 1960</u> Death occurred at <u>3:15 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>F.R. Bradley</u> F. R. BRADLEY, M.D.	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>9/9/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-9-60</u>	23c. NAME OF CEMETERY OR CREMATORIA <u>Old DuQuoin, Ill</u>	23d. LOCATION (City, town, or county) (State) <u>DuQuoin Ill.</u>
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24. FUNERAL DIRECTOR <u>NEAL</u> ADDRESS <u>DuQuoin, Ill</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 9 1960</u>	26. REGISTRAR'S SIGNATURE <u>Kearl Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

BARNES HOSPITAL

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 Frank Probst

Licensed Embalmer No. 4356

P. O. Address St Louis Mo

BARNES HOSPITAL

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.