

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2809th N. SARAH Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2809th N. SARAH Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Whitley Middle Last Hill			4. DATE OF DEATH Month December Day 20 Year 60		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 9-85	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Helena Ark.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Unk.		13b. MOTHER'S MAIDEN NAME Classic Walker		14. NAME OF HUSBAND OR WIFE Alice Hill	

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. 499-03-3712	17. INFORMANT Agnes Vann 2809th N. SARAH Address
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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: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 331x		INTERVAL BETWEEN ONSET AND DEATH -
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.)
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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 _____ to _____ and last saw her/him alive on _____.
 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Joseph M. Smith, M.D.		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 12-21-60
23a. BURIAL, CREATION, REMOVAL (Specify) Removal	23b. DATE 12/22/60	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Wm. Smith 4019 Washington	25. DATE RECD. BY LOCAL REG. DEC 23 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFRUIT 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

Wm Smith

Licensed Embalmer No. 4371

P. O. Address St. Louis

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.