

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		a. STATE Missouri	b. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5247 Theodosia		c. CITY OR TOWN Saint Louis	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 5247 Theodosia	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EMMA Middle E. Last SMITH			4. DATE OF DEATH Month December Day 9 Year 1960		
5. SEX Female	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 10/4/83	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (City and state or country) Ashley, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Hiram Rivere		13b. MOTHER'S MAIDEN NAME Nancy Fowler	14. NAME OF HUSBAND OR WIFE Elijah Smith
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. None	17. INFORMANT Address Warren Moore, 5247 Theodosia

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) Broncho pneumonia		2 days
DUE TO (b) Cerebral Thrombosis		1 yr.
DUE TO (c) 332x		

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	
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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 Dec. 3, 1960 to Dec. 9, 1960 and last saw her alive on Dec. 9, 1960
 Death occurred at Dec. 9, 1960 9:55 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>James M. Whitless, M.D.</i>	22b. ADDRESS 976 A. No. Taylor.	22c. DATE SIGNED 12-13-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/14/60	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
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24. FUNERAL DIRECTOR ADDRESS Charles J. Gates, 4107 Finney	25. DATE RECD. BY LOCAL REG. DEC 14 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Guifon Siva*
Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.