

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-017604

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1179

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

FILED APR 27 1962

VS 300
Rev. 4/59

14036
24836

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94200
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Pine Lawn		c. CITY OR TOWN Pine Lawn	
Length of stay in lb YRS.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6529 Woodrow		d. STREET ADDRESS (If outside, give location) 6529 Woodrow	
3. NAME OF DECEASED (Type or print) First William Middle J. Last Smith		4. DATE OF DEATH Month April Day 15 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-23-73
9. AGE (last birthday) 88		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) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (City and state or country) Dyersburg, Tenn.
12. CITIZEN OF WHAT COUNTRY U. S.		13a. FATHER'S NAME William Smith	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Della M. 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. <input type="checkbox"/>	
17. INFORMANT William Smith 945 Buckeye Dr., Ferguson.		Address	
18. CAUSE OF DEATH (Enter only one cause per line. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10-20 yrs	
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 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 5-17-60 to 4-15-62 and last saw ^{her} him alive on 4-14-62 Death occurred at 3:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leonard N. Piccione M.D.		22b. ADDRESS 6303 Natural Bridge Rd Pine Lawn, Mo	
22c. DATE SIGNED 4-16-62		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-18-62	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.
24. FUNERAL DIRECTOR White-Mullen Mortuary, Ferguson, Mo.		25. DATE RECD. BY LOCAL REG. 4-16-62	26. REGISTRAR'S SIGNATURE J. B. Muffley M.D.

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Reinhold K. Lohmann

Licensed Embalmer No. 3395

P. O. Address St. Louis 35 Mo

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.