

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26575
STATE FILE NUMBER

FILED JUL 16 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5794**

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 St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS 7171 Kingsbury	
3. NAME OF DECEASED (Type or print) MELLICENE SMITH		4. DATE OF DEATH June 21-1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13-1871
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) unk
13. FATHER'S NAME John Thurman		14. MOTHER'S MAIDEN NAME Cecelia Woodward	
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 Roosevelt Hardiman 7171 Kingsbury
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of kidney polycystic kidney, right DUE TO (b) Poly cystic kidney, Right bronchopneumonia, terminal DUE TO (c) Broncho pneumonia, terminal PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) had removal of cyst of kidney 6 days before death			INTERVAL BETWEEN ONSET AND DEATH 6 years
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) none	
20c. TIME OF INJURY Hour a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) none	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE 180x	
21. I attended the deceased from 6-5-57 , to 6-21-57 and last saw her alive on 6-20-57 Death occurred at 7 am, 2:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Type or print) D. S. Allen		22b. ADDRESS 18 So. Kingshighway	
22c. DATE SIGNED 6-21-57		22d. ADDRESS 18 South Kingshighway	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-24-1957	
23c. NAME OF CEMETERY OR CREMATORY Mount Vernon Cemetery		23d. LOCATION (City, town, or county) (State) Atchison, Kansas	
24. FUNERAL DIRECTOR ADDRESS C.R. Lupton & Sons 7233 Delmar Blvd.		25. DATE RECD. BY LOCAL REG. JUN 21 57	
25. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		26. REGISTRAR'S SIGNATURE S.P.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Arnold W. Schoene*

Licensed Embalmer No. 386

P. O. Address *St. Louis*

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