

FILED JUN 8 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17554

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 500		Registrar's No. 1210	
1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St. Louis</i>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Koch, Missouri</i>		c. LENGTH OF STAY (In this place) <i>3y. 7 mos</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>LEMAH 870</i>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>ROBERT KOCH HOSPITAL</i>				d. STREET ADDRESS (If rural, give location) <i>439 A Hoffmeyer or 2nd St. LeMah</i>			
3. NAME OF DECEASED (Type or Print) <i>Mayford</i>		a. (First) <i>O.</i>		b. (Middle) <i>Smith</i>		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) <i>5 23 1954</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	
8. DATE OF BIRTH <i>5-12-1909</i>		9. AGE (In years last birthday) <i>45</i>		10. MONTHS <i>45</i>		11. DAYS <i>45</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>truck driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Auto Trans Co.</i>		11. BIRTHPLACE (City and State or Foreign Country) <i>Flat River, Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Orin Smith</i>		13b. MOTHER'S MAIDEN NAME <i>Ella Snyder</i>		14. NAME OF HUSBAND OR WIFE <i>Thelma Hurt Smith</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>487-14-2513</i>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Thelma Hurt Smith Koch, Mo.</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>1X</i>			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>congestive heart failure due to cor pulmonale</i>				DUE TO (b) <i>pulmonary arteriosclerosis and</i>			
DUE TO (c) <i>chronic hypertrophic emphysema</i>				5-15y.			
II. OTHER SIGNIFICANT CONDITIONS <i>pulmonary tuberculosis, active</i>				4y			
Conditions contributing to the death but not related to the disease or condition causing death. <i>tuberculous empyema, right side of chest</i>				2y 9 mos.			
19a. DATE OF OPERATION <i>7</i>		19b. MAJOR FINDINGS OF OPERATION <i>5271 A</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>-</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>-</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>-</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>-</i>			
22. I hereby certify that I attended the deceased from <i>Oct. 24, 1950</i> , to <i>May 23, 1954</i> , that I last saw the deceased alive on <i>May 22, 1954</i> , and that death occurred at <i>6:40 Am.</i> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Harold S. Russell, M.D.</i>				23b. ADDRESS <i>Robert Koch Hospital, Koch, Mo.</i>		23c. DATE SIGNED <i>5-23-1954</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>5-24-54</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Local</i>		24d. LOCATION (City, town, or county) (State) <i>Desloge, Mo.</i>	
DATE REC'D BY LOCAL REG. <i>5-24-54</i>		REGISTRAR'S SIGNATURE <i>Hubert R. Donahue, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Albert H. Hoppe 4700 Washington</i>			

528 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 .....  
Student Embalmer

Signed

*J. Wm Bumbley*

Licensed Embalmer No. *3653*

P. O. Address *St Louis 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 this body is not embalmed, fact should be so stated above.