

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County.....
Township..... Registration District No. **791**
or..... Primary Registration District No. **1003** File No. **14380**
Village..... St. Louis Mo. St. Mary's Infirmary Registered No. **3404**
or.....
City..... NO. St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME *John Smektalaki*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Married</i>
6 DATE OF BIRTH <i>June 24th 1849</i> (Month) (Day) (Year)		
7 AGE <i>65 yrs. 9 mos. 17 ds.</i>	If LESS than 1 day.....hrs. or.....min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work..... <i>Cabinet maker</i> (b) General nature of industry business, or establishment in which employed (or employer).....		
9 BIRTHPLACE (City or town, State or foreign country) <i>Germany</i>		
PARENTS	10 NAME OF FATHER <i>John Smektalaki</i>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <i>Germany</i>	
	12 MAIDEN NAME OF MOTHER <i>Dont know</i>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <i>Dont know</i>	

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
April 10 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Apr 8* 1915, to *Apr 10* 1915, that I last saw him alive on *Apr 9* 1915, and that death occurred, on the date stated above, at *4 A* m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart
92A
95B
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY *Mitral Regurgitation*
(Secondary)
(Duration)..... yrs..... mos..... ds.
(Signed) *F. Schuff* M. D.
Apr 10 1915 (Address) *3206 Lafayette St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted if not at place of death?
1835 Cass Ave.

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL *Calvary* DATE OF BURIAL *April 13 1915*

20 UNDERTAKER *Aug Brockland Co* ADDRESS *1421 7-9 St.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *S. Smektalaki*
(Address) *1835 Cass Ave.*

15 Filed *APR 12 1915* *a. g. Snodgrass* Registrar
Dip.

