

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

Do not use this space.

12914

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo.** (No. **St. Louis Children's Hospital**)

File No.

Registered No. **3464**

2. FULL NAME **Robert S Smith**

(a) Residence No. **4164** **Laurel Ave.** **10** Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred **Life** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

—

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

11-19-26

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

2

4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Missouri

10. NAME OF FATHER

Ray Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Missouri

12. MAIDEN NAME OF MOTHER

Flora Lasse

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Missouri

14.

INFORMANT

(Address) **500 S. Kings Highway**

L. Kallberg

15.

FILED

21 1929

My O'Sterley

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

3-19 1929

17.

I HEREBY CERTIFY That I attended deceased from **2-28**, 19**29**, to **3-19**, 19**29**

that I last saw him alive on **3-19**, 19**29**, and that death occurred, on the date stated above, at **10:55 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Parenchymatous hepatitis

10 (duration) **1** yrs. **0** mos. **0** da.

CONTRIBUTORY **Diphtheria** (SECONDARY)

(duration) yrs. mos. **2** da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

10 **Home**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF **—**

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS **E. Lammation & Culture**

(Signed) **A. C. Edwards**, M. D.

3-19, 1929 (Address) 500 S. Kings Highway

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Stew. St Pauls. Church

Mar 22 19 29

20. UNDERTAKER

ADDRESS

My Leidner Und Co. N Market St

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.

11/11/20