

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

Do not use this space.

22852

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City..... *St. Louis Mo.* (No. ....) *Sanitarium*

File No.....  
Registered No. **6268**  
St. .... Ward)

**2. FULL NAME**

*Michael V Smith*  
(a) Residence. No. *6230 Magnolia Ave* *13* Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred *50* yrs. + mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**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>	
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE-OF <i>Emma Smith</i>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Aug. 9 - 1873</i>					
7. AGE	YEARS	MONTHS	DS	IF LESS than 1 day, ..... hrs. or ..... min.	
	<i>55</i>	<i>10</i>	<i>1</i>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <i>Printer</i>					
(b) General nature of industry, business, or establishment in which employed (or employer) <i>Unknown</i>					
(c) Name of employer					

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 10 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 29*, 1929, to *June 10*, 1929 that I last saw him alive on *June 10*, 1929, and that death occurred, on the date stated above at *11:20* a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Chronic Myocarditis*

*90B*

(duration) - yrs. *4* mos. *13* ds. +

CONTRIBUTORY (SECONDARY) *90B*

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *Unknown*

DID AN OPERATION PRECEDE DEATH? *No.* DATE OF: -

WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical*

(Signed) *William T Gittle*, M. D.

*6/10, 1929* (Address) *5400 Arsenal St.*

\*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.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

10. NAME OF FATHER *Unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

14. INFORMANT *William T Gittle M.D.*  
(Address) *5400 Arsenal St.*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *SS Peter & Paul Cem* DATE OF BURIAL *June 12, 1929*

15. FILED *10 1929* *W E Starkey*  
REGISTRAR

20. UMBERTAKER *Keety Bros 3029 Lafayette Ave*

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.

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