

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

Do not use this space.
3194
3359 **2788**
File No. _____
Registered No. **857**
St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... **ST. Louis** (No. **ST. Luke's Hospital**)

2. FULL NAME

Rose Anna Smith
(a) Residence. No. **1464 Goodfellow** St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.	4. COLOR OR RACE W.	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martin R. Smith		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 2, 1883		
7. AGE YEARS 46	MONTHS 8	DAYS 23
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Housewife (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) Louisiana Mo.		
10. NAME OF FATHER John T. McCallister		
11. BIRTHPLACE OF FATHER (CITY OR TOWN), (STATE OR COUNTRY) Illinois		
12. MAIDEN NAME OF MOTHER Frances Wade		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN), (STATE OR COUNTRY) Illinois		
14. INFORMANT Harold J. Horan (Address) 6711 Arsenal St.		
15. FILED Jan 21 1930 REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 25 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Dec 28th** 19**25**, to **Jan 25**, 19**30**, that I last saw h. or alive on **Jan 25**, 19**30**, and that death occurred, on the date stated above, at **2:35** p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
Pneumonia, Bronchial
(duration) **3** yrs. mos. ds.
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH. **Yes** DATE OF **Jan 21 30**
WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS
Clinical findings
(Signed) **Carl A. K. ... M. D.**
Jan 25, 1930 (Address) **3720 Washington**

*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
Valhalla Cemetery DATE OF BURIAL **Jan 27 1930**

20. UNDERTAKER
Shepard Funeral Home ADDRESS **1167-69 Hamilton**

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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