

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

Do not use this space.
21347
21347
File No. _____
Registered No. **6219**
_____ St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital #1**)

2. FULL NAME

Philip J. Smith
(a) Residence No. **2845 S. 4th** St., **2/4** Ward. (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 M	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
-

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

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
alt 66	-	-	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Labour**
(b) General nature of industry, business, or establishment in which employed (or employer) **Unknown**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Mass.**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT **J. W. Kerner**
(Address) **Coroner's Office**

15.

FILED **1913** **May 2** **Standley**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6/12/30** 19
17. **The Physician or Attending**
I HEREBY CERTIFY, That I attended deceased from
_____, 19____, to _____, 19____,
that I last saw h. _____ alive on _____, 19____, and that
death occurred, on the date stated above, at **12:08 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic - Myocarditis
73c

CONTRIBUTORY (SECONDARY)

90B

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY **Yes**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **J. W. Kerner** M.D.

6/26/30 (Address) **Dep. Coroner**

*State the DISEASE CAUSING DEATH, (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

Walters Field

DATE OF BURIAL

6/26 19 30

20. UNDERTAKER

Ziegenhew Bros

ADDRESS

Cherokee

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.

