

JAN 13 1936

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

Do not use this space.

791

41216

1. PLACE OF DEATH

County..... Registration District No.....  
Township..... Primary Registration District No. 1003  
City *Saint Louis Mo. 3390 Park Ave*

File No.....  
Registered No. 10428  
St. .... Ward)

2. FULL NAME

*Mary Ella Smith*

(a) Residence, No. *13390 Park Ave* St. *17* 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec. 7* 19*35*

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF *Barth Smith, deceased*

22. I HEREBY CERTIFY, That I attended deceased from *Aug 8* 19*35* to *Dec 7* 19*35*  
I last saw *her* alive on *Dec 7* 19*35* Death is said to have occurred on the date stated above, at *9:30 p.m.*  
The principal cause of death and related causes of importance were as follows:  
*Arterio Sclerosis*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 16 - 1865*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*70 7 21*

Date of onset *12-1-31*

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Home Work*  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *at Home*  
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

Other contributory causes of importance:  
*Chronic Intestinal Myofasciitis* *131* *8.8.35*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Cinn Ohio*

FATHER  
13. NAME *Michael O'Leary*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

MOTHER  
15. MAIDEN NAME *Mary Phelan*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

17. INFORMANT *Mrs. Alice Smith*  
(ADDRESS) *3390 Park Ave*

18. BURIAL, CREMATION, OR REMOVAL  
PLACE *Calvary* DATE *Dec 11* 19*35*

19. UNDERTAKER *Edw. J. Howard & Sons*  
(ADDRESS) *4213 St. Louis Ave*

20. FILED *1* 1935 19 *J. Bredeck* Registrar.

Name of operation..... Date of.....  
What test confirmed diagnosis? *Chronic* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury..... 19.....  
Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *no*  
If so, specify.....  
(Signed) *John W. Macdonald*, M. D.  
(Address) *534 N. Grand*

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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