

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.

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

33009

Do not use this space.

## 1. PLACE OF DEATH

(a) County..... Registration District No. 791 1003  
(b) Township..... Primary Registration District No. 9063  
(c) City ST. LOUIS MO. (d) Street No. 1540A CALIFORNIA AV. St. EN ROUTE CITY HOSPITAL  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. 1540A CALIFORNIA AV. 23 (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JULY 23-1897

7. AGE YEARS 40 MONTHS 2 DAYS 3 If LESS than 1 day, ..... hrs. or ..... min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

FATHER 13. NAME CHARLES SMITH

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNK.

MOTHER 15. MAIDEN NAME DELIA ANGLIN

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNK.

17. INFORMANT (ADDRESS) ELIZABETH SMITH  
1540A CALIFORNIA AV.

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY CEM. DATE SEPT. 1937

19. FUNERAL DIRECTOR E. J. SEHNUR  
SEP 23 1937 1540A CALIFORNIA AV.

20. FILED St. Bredeck Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) SEPT. 26 1937

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at 4:20 P.M.  
The principal cause of death and related causes of importance were as follows:

Aortic Régurgitation;  
Mitral Régurgitation;  
Cardiac Hypertrophy.

Date of onset

Other contributory causes of importance: 9/26

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? yes

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 See above.  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify.....  
(Signed) Joseph M. Quinn M.D.  
(Address) District Coroner

STATEMENT BY LICENSED EMBALMER

2260

2260

I, James G. Sullivan

Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. F.

No. \_\_\_\_\_ or by

Joe B. Vollmer

Registered Apprentice No.

working under my personal supervision

Signed

James G. Sullivan

Licensed Embalmer No.

2260

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**