

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

801  
1003

12481  
Do not use this space.

REC'D MAY 10 1938

1. PLACE OF DEATH

- (a) County..... Registration District No.....
- (b) Township..... Primary Registration District No.....
- (c) City St. Louis Mo (d) Street No. Barnes Hospital St. (If death occurred in Hospital or Institution, write its name instead of street and number)
- (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.

Registered No. **3085**

2. PRINT FULL NAME John Harrison Smith 530

- (a) Residence, No. (Usual place of abode, if no street address, write county or city) St. NR Cook Station Mo (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married</b>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Ellen Smith</b>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>6-21-1857</b>				
7. AGE YEARS <b>80</b>	MONTHS <b>9</b>	DAYS <b>10</b>	If LESS than 1 day, .....hrs. or .....min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>ret. farmer</b>			
	9. Industry or business in which work was done, as saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **3-31-1938**

22. I HEREBY CERTIFY, That I attended deceased from **3-25-1938**, to **3-31-1938**. I last saw him alive on **3-31-1938**. Death is said to have occurred on the date stated above, at **6:15 a. m.**

The principal cause of death and related causes of importance were as follows:

**CA of prostate Unemin Bronchiopneumonia**

Date of onset **6 mo**  
**3/26/38**  
**3/29/38**

Other contributory causes of importance:

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Allabama</b>
	13. NAME <b>Elias Jefferson Smith</b>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Unknown</b>
	15. MAIDEN NAME <b>Unknown</b>
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Unk nown</b>	
17. INFORMANT <b>O. B. Smith</b> (ADDRESS) <b>4730 Beacon St.</b>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Cook Station Mo</b> <b>4-1-1938</b>	
19. FUNERAL DIRECTOR <b>Alexander Home</b> (ADDRESS) <b>6175 Delmar Blvd.</b>	
20. FILED <b>APR 1 1938</b> <b>J. P. Brudick</b> Local Registrar	

Name of operation **none** Date of **---**

What test confirmed diagnosis? **cytoscopic** 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..... Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **no** If so, specify..... (Signed) **J. S. Ellis**, M. D. (Address) **Barnes Hosp.**

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.

U. S. GOVERNMENT PRINTING OFFICE: 1933  
FORM 7-2-37  
1 X12004

STATEMENT BY LICENSED EMBALMER

I, J. W. M. Dinkley, Licensed Embalmer No. 3653  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by self  
L. E.  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed J. W. M. Dinkley  
Licensed Embalmer No. 3653

**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.)**