

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.

1781

1938

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

40826  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. **791**

(b) Township ..... Primary Registration District No. **10083**

(c) City **Saint Louis** (d) Street No. **4330 Labadie Avenue** St. **10518**

(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 **Martha Smith**

(a) Residence, No. **4330 Labadie Avenue** St. **10** (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Robert M. Smith**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **February 12, 1893**

7. AGE YEARS **45** MONTHS **9** DAYS **22** If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Waverley Missouri**

FATHER

13. NAME **Ewing**

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

MOTHER

15. MAIDEN NAME **Matilda**

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

17. INFORMANT (ADDRESS) **Robert M. Smith 4330 Labadie Avenue**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Washington Park** DATE **Dec. 8, 1938**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Charles J. Gates 4107-09 Finney Avenue**

20. FILED **DEC 8 1938** **J. P. Brubaker** Local Registrar

MEDICAL CERTIFICATE OF DEATH

**No Physician in Attendance**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **December 4th, 1938**

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 **9:25 AM**

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

**Coronary Sclerosis. (Occlusion)**  
**Diffuse Arteriosclerosis.**

Date of onset

Other contributory causes of importance:

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?.....  
If so, specify.....  
(Signed) **Walter J. Gentry**  
(Address) **1300 Clark Avenue**

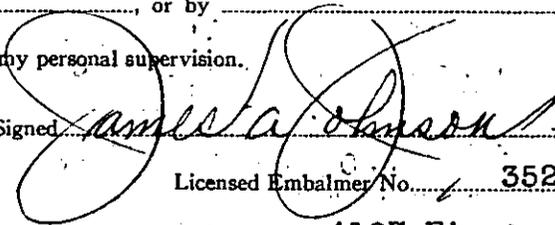
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

**James A. Johnson**

or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed 

Licensed Embalmer No. **3522**

P. O. Address **4107 Finney Ave.**

**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.)**

**If this body is not embalmed, above space should be left blank.**