

REC'D FEB 10 1939

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

212

Do not use this space.

## 1. PLACE OF DEATH

(a) County.....  
(b) Township.....  
(c) City St. Louis (d) Street No. Desloge Hospital (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.

791  
1003

Registered No. 212

## 2. PRINT FULL NAME

530 Cora Smith  
(a) Residence, No. 2621 So 12th. St. St. 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 Female 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 John F. Smith  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Abt. 1889  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. Abt 50 Unknown  
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) St. Louis, Mo.  
13. NAME Unknown  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
15. MAIDEN NAME Unknown  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
17. INFORMANT (ADDRESS) Edward Smith  
2621 So. 12th. St.  
18. BURIAL, CREMATION, OR REMOVAL PLACE Collinsville Ill. DATE 1/9/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. C. Moydell  
1926 Allen, Ave.  
20. FILED 18 3 1939  
J. O. Breech  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-5 1939  
22. I HEREBY CERTIFY, That I attended deceased from 12-29 1939 to 1-5 1939  
I last saw him alive on 1-5 1939. Death is said to have occurred on the date stated above, at 6:15 p.m.  
The principal cause of death and related causes of importance were as follows:

Hypertensive Cardio-vascular disease  
Cerebral hemorrhage  
Date of onset 1-5-39

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.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify..... (Signed) G. O. Brown, M. D.  
(Address) 1325 So. Grand

(Licensed Embalmer's Statement on Reverse Side)

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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**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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Benj. C. Juman*

.....  
Licensed Embalmer No. *2272*

P. O. Address *1926 Allen 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.**