

DEC'D MAR 13 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS 791  
CERTIFICATE OF DEATH

4510  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Mo Registration District No. 3  
(b) Township St. Louis Mo Primary Registration District No. 1008  
(c) City St. Louis Mo (d) Street No. 1203 Registered No. 1203  
(If death occurred in Hospital or Institution write its name instead of street and number) St. St. Louis Mo  
(e) Length of residence in city or town where death occurred yrs. mos. 2 (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

5.30 Leslie G. Smith  
(a) Residence, No. 905 Market St St. 25 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
abt 50

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. unemployed  
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) Kansas

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 Thomas Brady  
(ADDRESS) Civil Courts Bldg

18. BURIAL, CREMATION, OR REMOVAL PLACE Springfield Mo DATE 2/7 1939

19. FUNERAL DIRECTOR (NAME) Ellinger & Kunz  
(ADDRESS) Springfield Mo

20. FILED FEB 7 1939 J.P. Budak Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/5 1939

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 9:00 P.M.  
The principal cause of death and related causes of importance were as follows:

Chronic Arteritis  
Coronary unknown  
myocardial and cystic degeneration of  
kidney's no stones  
Oedema of Brain  
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 \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) J. West M. D. M. D.  
(Address) Deputy Coroner

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.

STATEMENT BY LICENSED EMBALMER  
CERTIFICATE NO. 2245

---

---

**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.....

*Frank J. Owens*

Licensed Embalmer No. 2245

P. O. Address.....

**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.**