

1939 APR 12 1939

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

8822  
Do not use this space.

791  
1003

2587

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City St. Louis (d) Street No. De Paul 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.

2. PRINT FULL NAME 530 AUGUST C. SMITH,

(a) Residence, No. Overland, Mo. St. NR  
(Usual place of abode, if no street address, write county or city) (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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Theresa Smith (Boman)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 30, 1912

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min.  
26 11 15

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

FATHER 13. NAME Fred Smith

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

MOTHER 15. MAIDEN NAME Dora Ferguson

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

17. INFORMANT (ADDRESS) Fred Smith Overland, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove DATE Mar. 20, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Math. Hermann & Son 2161 East Fair Avenue

20. FILED MAR 18 1939 J. B. Beck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 17, 1939

22. I HEREBY CERTIFY That I attended deceased from March 12, 1939 to March 17, 1939  
I last saw him alive on March 16, 1939. Death is said to have occurred on the date stated above, at 9:00 A. M.

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

Uremia  
Septicemia, acute  
gonococci  
1256

Other contributory causes of importance:  
Acute gonorrheal urethritis  
acute hepatitis

Name of operation Sciatic ataxia Date of 3-14-39  
What test confirmed diagnosis? Lab. tests 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) John T. Cah, M.D.  
(Address) 33 No. Madison Clayton Mo.

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.

WHILE PLAIN; WITH UNFADING INK—THIS IS A PERMANENT RECORD

I X10000

**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.....

*Dwight Hampton*

Licensed Embalmer No.....

*2967*

P. O. Address.....

*2161 E. Fair 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.**