

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

REG. 2-17-35  
REV. 1-1-35  
1 X19311

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.

Registration District No. **791** SEP 14 1939

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis, Missouri**  
(c) Name of hospital or institution: **City Hospital**  
(d) Length of stay: In hospital or institution **18 Days**  
In this community **20 yrs.**

3. (a) PRINT FULL NAME **530 Margaret Smith**  
(b) If veteran, name war **No**  
(c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Unknown**

8. AGE: Years **About 64** Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Kentucky**

10. Usual occupation **At Home**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Unknown Penn**  
13. Birthplace **Unknown**  
14. Maiden name **Unknown**  
15. Birthplace **Unknown**

16. (a) Informant's own signature **Paula Kemper**  
(b) Address **RFD, St. Clair, Missouri**

17. (a) **Burial** (b) Date thereof **Aug. 15, 1939**  
(c) Place: burial or cremation **Mt. Hope Cemetery**

18. (a) Signature of funeral director **P. Hoffmeister W.L.Co.**  
(b) Address **7814 S. Broadway**

19. **AUG 15 1939** (b) **J.F. Rudwick**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(d) Street No. **323 Lafayette ave.**  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **August** day **11**, year **1939** hour **2:35** minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from **July 23**, 19**39**, to **August 11**, 19**39**, and that death occurred on the date and hour stated above.

that I last saw her alive on **August 11**, 19**39**,  
Immediate cause of death **Cerebral hemorrhage of liver** Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
28. Signature **Paul J. Davis** (M. D. or other)  
Address **City Hospital** Date signed **8/11/39**

**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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

**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.**