

REGISTRATION DISTRICT NO. 791

Primary Registration District No. _____

1. PLACE OF DEATH:

1003

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Johns Hospital.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 47 Days.
(Specify whether _____)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME Lucyle E. Smith. 530

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clarence B. Smith. 6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased April 10, 1906.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>33</u>	<u>4</u>	<u>7</u>	hr. _____ min. _____

9. Birthplace Clarksville, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business at home

MOTHER FATHER { 12. Name John Todd.

13. Birthplace Dont know.
(City, town, or county) (State or foreign country)

14. Maiden name Clyde Fielders.

15. Birthplace Clarksville, Missouri.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mr. Clarence B. Smith.

(b) Address 2832 Clifton Ave.

17. (a) Burial (b) Date thereof 8-19-1939.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation xxxxx Lake Charles Cemetery

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.

(b) Address 5966-68 Easton Ave.

19. (a) AUG 18 1939 (b) J. F. Brubaker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis. 131
(If outside city or town limits, write "RURAL")
 (d) Street No. 2832 Clifton Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17th.
 year 1939. hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from May 20, 1939 to 8-17, 1939
 that I last saw her alive on 8-17, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Lymphatic Leukemia
 Duration _____

Due to _____
 Due to _____

Other conditions Bell's Palsy
(Include pregnancy within 3 months of death)

Major findings: No operation
 Of operations _____
 Of autopsy Enlarged Liver + Spleen - Purpura.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? _____
(City or town) (County) (State)

(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 _____

23. Signature [Signature] (M. D. or other) _____

Address 705 Humboldt Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.

Dr. L. Will
539 N. Grand
10 a.m. to 3 P.M.
Jefferson 9727

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 3454

David C. Gibson, Registered Apprentice No. _____
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

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.