

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34801**
Registrar's No. **9339**

Registration District No. **1002**

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(c) Name of hospital or institution: **Mo. Baptist Hospital**
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **Troy**
(d) Street No. _____
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Eugenia Allen Smith 530**
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **30**
year **1939** hour **11** minute **45 P.M.**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 12 1874**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May**, 1939, to **Oct 30**, 1939;
that I last saw her alive on **Oct 30**, 1939;
and that death occurred on the date and hour stated above.

8. AGE: Years **65** Months **2** Days **18** If less than one day _____ hr. _____ min.

Immediate cause of death **Chronic Myocarditis**

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

Due to **Hypertension**

10. Usual occupation **Housewife**

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

MOTHER FATHER
11. Industry or business _____
12. Name **Joseph Allen**
13. Birthplace **Troy, Missouri**
14. Maiden name **Katherine Baker**
15. Birthplace **Troy, Missouri**

Major findings: _____
Of operations _____
Of autopsy **no**

16. (a) Informant's own signature **Allen W. Smith**
(b) Address **Troy, Mo.**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **no**
(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? _____

17. (a) **Removal** (b) Date thereof **10/31/39**
(c) Place: burial or cremation **Troy, Mo.**

While at work? _____ (Specify type of place)
(e) Means of injury _____

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Ave.**
19. (a) **OCT 31 1939** (b) **J. F. Bedeck**
(Date received locally) (Registrar's signature)

23. Signature **Joseph E. Carney** (M. D. or _____)
Address **1525 Missco Bldg** Date signed **10/31/39**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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:

No Embalmer

Signed.....

Licensed Embalmer No.....

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.