V. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9482

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2965

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town St Louis 25 (If outside city or town limits, write "RURAL")
(d) Street No. 1431 A No 9th (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME WALTER SMITH
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex male
5. Color or race Col
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years abt 75 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Texas (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Unknown 9
13. Birthplace " (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name " 1
15. Birthplace " (City, town, or county) (State or foreign country)
16. (a) Informant John Berkey - P.D.
(b) Address 3430 Eads
17. (a) (Burial, cremation, or removal) (b) Date thereof 3/8/40 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Pa
18. (a) Signature of funeral director Ben Compton Board
(b) Address W. Richter 3800 Ridge
19. (a) MAR 29 1940 (Date received local registrar) (b) J. F. Bradick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 24 year 1940 hour 2 minute 45 P. M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	
Due to	
Due to Chronic Interstitial Nephritis	
Other conditions (Include pregnancy within 3 months of death)	
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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 5
23. Signature Joseph M. [illegible] (M.D. or other)
Address Deputy Coroner Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

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.