

REGISTRATION DISTRICT NO. _____

Primary Registration District No. _____

Registrar's No. **4405**

1. PLACE OF DEATH:

(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:
3745a BELL AVE
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
 (c) City or town ST LOUIS 11
(If outside city or town limits, write "RURAL")
 (d) Street No. 3745a BELL AVE
(If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years

8. (a) PRINT FULL NAME MARY FRANCIS SMITH 530

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

6. (b) Name of husband or wife John Harris 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased March 10 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>2</u>	<u>6</u>	hr. _____ min.

9. Birthplace Clinton Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business _____

MOTHER FATHER { 12. Name unknown ?
 13. Birthplace unknown ?
(City, town, or county) (State or foreign country)

{ 14. Maiden name Elizabeth Harris
 15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Harris

(b) Address 3745a Bell Ave

17. (a) _____ (b) Date thereof 5-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director A. F. Boudrie Walker
(b) Address 728 Stoddard St.

19. (a) MAY 17 1940 (b) J. Boudrie
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16
year 1940 hour 17 minute P M.

21. I hereby certify that I attended the deceased from Feb 13, 1940, to May 17, 1940;
that I last saw him alive on May 17, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death chronic nephritis
chronic
Due to _____
Due to 131

Other conditions chronic myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy no

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. Boudrie (M. D. or other) _____
Address Stoddard St. Date signed _____

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

WHILE FILLING IN—USE UNFADING 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.

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 Robert A. Powell

Licensed Embalmer No. 3402

P. O. Address 3100 Franklin

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.