

AUG 25 1940
Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

6250

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days (Specify whether
 In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
 (c) City or town Olney (If outside city or town limits, write "RURAL") N.R.
 (d) Street No. North Walnut (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Clyde Lonzo Smith 530
 3. (b) If veteran, 328-65-0351 name war No
 3. (c) Social Security No. No

4. Sex MALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Marie 6. (c) Age of husband or wife if alive 30 years
 7. Birth date of deceased June 5 1908
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
32 5 26 hr. min.

9. Birthplace Clay Co. Ill.
 (City, town, or county) (State or foreign country)

10. Usual occupation Bus. Salesman

11. Industry or business _____
 12. Name N. E. Smith
 13. Birthplace Owens Co. Ind.
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Byers
 15. Birthplace Clay Co. Ill.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Marie Smith
 (b) Address Olney, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-27-40
 (Month) (Day) (Year)
 (c) Place: burial or cremation Olney, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Ave.

19. (a) JUL 26 1940 (Date received local registrar) (b) J. F. Brodeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
 year 1940 hour 7 minute 10 P. M.
 21. I hereby certify that I attended the deceased from Sunday
July 21, 1940, to July 25, 1940;
 that I last saw him alive on July 25, 1940,
 and that death occurred on the date and hour stated above.
 Immediate cause of death Circulatory
failure. Duration _____

Due to Subacute Bacterial
endocarditis

Due to _____

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?

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

23. Signature R. Wellish (M. D. or other) _____
 Address BARNES HOSPITAL Date signed 7-26-40

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.....

J. G. Sullivan

Licensed Embalmer No. 1122

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.