

SEP 25 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6543

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: H G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mos 3 das
In this community 27 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME CHARLES SMITH 530

3. (b) If veteran, name war Unk 3. (c) Social Security No. Unk

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Sep

6. (b) Name of husband or wife Unk 6. (c) Age of husband or wife if alive Unk years

7. Birth date of deceased January 6, 1902
(Month) (Day) (Year)

8. AGE: Years 38 Months 5 Days 24 If less than one day hr. min.

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

10. Usual occupation Unk

11. Industry or business Unk

12. Name John Smith 9

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

14. Maiden name Sarah Davis 9

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

16. (a) Informant Clorence A Spotts

(b) Address H G Phillips Hospital

17. (a) (b) Date thereof 7-3-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Ruthen

19. (a) AUG 2 1940 (b) J. F. Tradeck
(Date received local registrar) (Registrar's signature)

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. 3812 Finney
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1940 hour 5:50 minute P.M.

21. I hereby certify that I attended the deceased from May 27, 1940, to June 30, 1940;
that I last saw him alive on June 30, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis About 3 years
Duration

Due to _____
Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN

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) _____
(a) Means of injury _____
23. Signature Edell M. V. V. V. V. V. (M. D. or other) _____
Address _____ Date signed _____

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

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.