o. 2
13-40
7-39
X23159

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

FILED OCT 20 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30587

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 7864

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: Park Lane Hospital
(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 Mo. (b) County

(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")

0 (d) Street No. 2831a Union Blvd.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Infant Smith

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept. (Month) 19 (Day) 1940 (Year)

8. AGE: Years | Months | Days | If less than one day 16 hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation 1

11. Industry or business 1

FATHER
12. Name James A. Smith
13. Birthplace (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Anne Scheer
15. Birthplace (City, town, or county) Oklahoma (State or foreign country)

16. (a) Informant James A. Smith
(b) Address 2831a Union Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-40 (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.

19. (a) SEP 21 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19
year 1940 hour 5 30 minute P M.

21. I hereby certify that I attended the deceased from 1-15 am Sept 19- 1940, to 5 30 P.M. Sept 19 1940
that I last saw her alive on 2 P.M. 9-19- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Baby was still born. revived but at no time developed normal respiration

Due to died 16 hours after birth.

Due to Death due to inter cranial pressure - due to very difficult labor.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 1

23. Signature O Richard Bullard (M. D. ~~or other~~)
Address 3829 Westminster Date signed 9-19-40

(Licensed Embalmer's Statement on Reverse Side)

3829 Westminster
2-4 PM

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 No Embalming

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, fact should be so stated above.