

Registration District No. 791Primary Registration District No. 1003

## 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:  
City Hospital #1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME Irene Smith3. (b) If veteran,  
name war \*\*\*\*\*3. (c) Social Security  
No. \*\*\*\*\*

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married,  
divorced Married  
 6. (b) Name of husband or wife Robert Smith  
 6. (c) Age of husband or wife if  
alive 65 years  
 7. Birth date of deceased February 12 1878  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 7 12 hr. min.9. Birthplace Illinois  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Henry Claypoole13. Birthplace Illinois  
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Robert Smith(b) Address Columbus Ohio17. (a) Burial (b) Date thereof Sept 28 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Memorial Park18. (a) Signature of funeral director Peetz Brothers(b) Address 3029 Lafayette Ave19. (a) SEP 28 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Signature of registrar)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 25  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1725 A. Franklin Ave  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 24th  
year 1940 hour 7:42 minute \_\_\_\_\_ P. M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Phthisis Pulmonalis Duration  
(Pulmonary Tuberculosis); Contrib:  
Chronic Diffuse Nephritis; Fractured  
Due to Ribs; suffered in fall through  
opening on second floor porch to  
ground below, at 1725b Franklin  
Ave., on Aug. 31st, 1940, at about  
11:40 A.M.  
 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) Accident(b) Date of occurrence August 31st, 1940(c) Where did injury occur? St. Louis, Mo.  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
25 About home

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Robert Smith (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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**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..... *Frank J. Owen* .....

Licensed Embalmer No. *2245* .....

P. O. Address *St Louis Mo* .....

**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.**