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23159

State File No. _____

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1650

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Station Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days. 3
(Specify whether)

In this community Unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County ---

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

(d) Street No. 4940 Wren Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Clifford T. Smith.

3. (b) If veteran, name war World's War

3. (c) Social Security No. ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 29th
year 1940 hour 11 minute 45 AM.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased May 23, 1892.
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from September 16, 1940 to September 29, 1940;
that I last saw him alive on September 29, 1940;
and that death occurred on the date and hour stated above.
Immediate cause of death 1. Cholecystitis,
2. Cholelithiasis.

8. AGE: Years Months Days If less than one day

48 4 6 hr. _____ min.

Due to _____

Due to _____

Other conditions Peritonitis, generalized
(Include pregnancy within 3 months of death)
following Cholecystectomy.

Major findings: Inflammation and atrophy
of Gall Bladder with stone.

Of autopsy Not performed.

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

10. Usual occupation Enrollee.

11. Industry or business Civilian Conservation Corps.

MOTHER FATHER { 12. Name Thomas R. Smith.

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

14. Maiden name Marie Ann Smith

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

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 ---

16. (a) Informant Walter G. Smith.

(b) Address 4940 Wren Ave., St. Louis, Mo.

17. (a) Burial. (b) Date thereof Oct 2, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery of B. No

18. (a) Signature of funeral director Philander Craig

(b) Address 4468 Washington

19. (a) OCT - 1 1940 (b) DR McJernigan
(Date received local registrar) (Registrar's signature)

23. Signature R. L. KASHA, MD Contract Surgeon
Address Station Hospital, I.B.M.C. Date signed 9-30-40

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.....

Philip M. Bernig

Licensed Embalmer No.....

3281

P. O. Address.....

4468 Washington

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, fact should be so stated above.