

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 37162
Registrar's No. 9435Registration District No. 791Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County _____
 (b) City or town Saint Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Saint Louis Maternity 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

8. (a) PRINT FULL NAME Frances Pauline Smith8. (b) If veteran, name war None 8. (c) Social Security No. None4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased November 8, 1940
(Month) (Day) (Year)8. AGE: Years _____ Months _____ Days 8 If less than one day _____ hr. _____ min.9. Birthplace Saint Louis, Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER
 { 12. Name Allen Glen Smith
 { 18. Birthplace Saint Louis, Missouri
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Kathryn Kasten
 { 15. Birthplace Burlington, Iowa
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature St. Louis Maternity Hospital(b) Address 630 S. Kingshighway Blvd.17. (a) Burial (b) Date thereof 11-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Sunset Burial Park18. (a) Signature of funeral director Kriegshauser Mortuar(b) Address 4228 So. Kingshighway Blvd.19. (a) NOV 18 1940 (b) J. B. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County _____
 (c) City or town Saint Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 502 Bellerive Boulevard
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 16, 1940
year _____ hour 10:50 minute _____ P. M.21. I hereby certify that I attended the deceased from November 8,
1940, 19____, to November 16, 1940;
that I last saw her alive on November 16, _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Menigitis - Non Lepidum
 Due to Spina Bifida - Hydrocephalus
 Due to _____

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? _____

23. Signature _____ (Specify type of place)
While at work? _____ (a) Means of injury _____23. Signature [Signature] (M. D. or other) M. D.
Address 3728 Washington Date signed 11/14/40

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.....

Edwin A. McQuinn
.....
Licensed Embalmer No. *3024*

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.