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17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37402

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 9675

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 7 yr 11 mo. 13 (Specify whether
In this community About 50 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (13)
(If outside city or town limits, write "RURAL")

(d) Street No. 1726 No. Euclid Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME ROSE MAXWELL SMITH

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Michael Smith

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

7. Birth date of deceased December (Month) 30, (Day) 1876 (Year)

8. AGE: Years 63 Months 10 Days 25 If less than one day hr. min.

9. Birthplace Warrenton (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Saleswoman 5

11. Industry or business Retail

FATHER
12. Name Lawrence Maxwell 5
13. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Mary McGarry
15. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Peter Todd
(b) Address 5400 Arsenal St

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-26-40 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEMETARY

18. (a) Signature of funeral director Albert H Hoppe
(b) Address 4700 Washington Av

19. (a) NOV 25 1940 (Date received local registrar) (b) J F Bridack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24th year 1940 hour 1:20 minute A. M.

21. I hereby certify that I attended the deceased from July 1st 1939, 19 , to Nov. 23, 1940, 19 ; that I last saw her alive on Nov. 23, 1940, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis 7-1-39	x
Due to Pernicious Animia 7-1-39	x
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy NONE	

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

23. Signature W Gandosey (M. D. or other)
Address 5400 Arsenal St. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 J. S. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.