

Registration District No. **784**

Primary Registration District No. **200**

Registrar's No. **756**

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

1. PLACE OF DEATH:

(a) County St. Louis  
(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: Mt. St. Ann's Sanatorium **4**  
(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)

In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME SMITH, Clyde T.

3. (b) If veteran, name war Worlds war 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Rose Smith 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Jan. 25, 1891  
(Month) (Day) (Year)

8. AGE: Years 50 Months 2 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Insurance Broker

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

MOTHER FATHER { 12. Name Tilghman Smith 13. Birthplace Don't Know 9

{ 14. Maiden name Cassie Tipton 15. Birthplace Don't Know 9

16. (a) Informant Mrs. Rose Smith

(b) Address 5968 Cote Brillante Ave.

17. (a) Burial (b) Date thereof April 7/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament Ave.

19. (a) APR 5 1941 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis **000**  
(c) City or town St. Louis, Missouri **7**  
(If outside city or town limits, write "RURAL") **9**  
(d) Street No. 5968 Cote Brillante  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 5  
year 41 hour 2 minute 8 a.m. M.

21. I hereby certify that I attended the deceased from 3/18, 1941 to 4/5, 1941;  
that I last saw him alive on 4/5, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Far advanced Pulmonary Tuberculosis Duration 20 yrs.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_ **13 (a)**

Other conditions Tuberculous Emphysema **3 yrs.**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy Emphysema (pt) with fleec throughout Rt. lung. Pulmonary **3 yrs.**  
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? \_\_\_\_\_

7.07 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. E. Gerson (M. D. or other) **1**  
Address Mt. St. Ann's Sanatorium Date signed 4-5-41

AUG 28 1941

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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.....

Licensed Embalmer No. 3225

P. O. Address 1125 Hodiamont Ave.

**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.**