

Registration District No. **791**

Primary Registration District No. **1003**

State File No.

Registrar's No.

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:
1612 N. Jefferson Ave.
(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 **40 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County.....

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

(d) Street No. **1612 N. Jefferson Ave.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Flora Smith**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **24th.**
year **1942** hour **5:30 PM.** minute..... M.

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife **Alexander, Isaac**

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

7. Birth date of deceased **Dec 28th. 1860**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death.....

8. AGE:

Years	Months	Days	If less than one day
81	xx	26	hr. min.

Due to **Chronic Myocarditis**
Chronic Interstitial Nephritis

Due to.....

9. Birthplace **Arcadia** **Mo**
(City, town, or county) (State or foreign country)

Other conditions.....
(Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**

11. Industry or business **At Home**

Major findings:
Of operations.....

Of autopsy.....

MOTHER FATHER

12. Name **Unknown**

13. Birthplace **U.S.A.**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **U.S.A.**
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant **Lula Moran**

(b) Address **8226 Watson Rd.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

17. (a) Burial (b) Date thereof **1/28/42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemt.**

(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?.....

18. (a) Signature of **Harrigan & Sheahan Und Co**

(b) Address **4415 Washington Blvd.**

While at work?.....
(Specify type of place) (e) Means of injury

19. (a) JAN 28 1942 (b) **J.P. Meade**
(Date received local registrar) (Registrar's signature)

23. Signature **Thomas F. Callahan** (M. D. or other)
Address **Depot, Carona** Date signed **1/28/42**

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

178

000
20
9

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 *Glenn E. Linderson*

Licensed Embalmer No. *4141*

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, fact should be so stated above.