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DM-24-41  
Rev. 5-17-39  
X2944

39344

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 14 1943

318

Registration District No. \_\_\_\_\_

1003

Registrar's No. 179

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: Isolation Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12-29-42/1-1-43  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Bond  
(c) City or town Mulberry Groves, Ill. Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Mulberry Groves  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 2

3. (a) PRINT FULL NAME Donna Elaine Smith,

(b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased Feb 8 1935  
(Month) (Day) (Year)

8. AGE: Years 7 Months 10 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER  
12. Name LeRoy Smith  
13. Birthplace Illinois (City, town, or county) (State or foreign country)  
14. Maiden name Bessie Perkins  
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant LeRoy Smith  
(b) Address Mulberry Grove, Illinois

17. (a) Removal (b) Date thereof 1/3/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mulberry Grove, Ill

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

19. (a) JAN 5 1943 (b) J. F. Prudek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Months January day 1  
year 1943 hour 11 minute 10 A. M.

21. I hereby certify that I attended the deceased from 12-29 1942 to 1-1-1943  
that I last saw er alive on 1-1-1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Meningococccemia Duration \_\_\_\_\_

Due to 6

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy Bronchopneumonia, patchies in viscera + brain

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 0

23. Signature Dr. Maxwell (M. D. or other) \_\_\_\_\_  
Address 5600 Arsenal St. - Louis Date signed 1-1-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MAY 3 1943

*City*

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 *Harford G. Burnley*  
Licensed Embalmer No. *4202*

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, fact should be so stated above.