U. S. No. 2
OM—9-4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16611

Registration District No. 2

Primary Registration District No. 1003

Registrar's No. 4484

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

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Marys Infirmary

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days. (Specify whether years, months or days)

In this community 22 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 711

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

(d) Street No. 4403 a Easton (If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: BIRDIE SMITH.

3. (b) If veteran, name war: —

3. (c) Social Security No. —

4. Sex: Female

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Samuel C. Smith

6. (c) Age of husband or ~~wife~~ if alive: 48 years

7. Birth date of deceased: Sept. (Month) 15 (Day) 1898 (Year)

8. AGE: Years 44 Months 7 Days 27 If less than one day ... hr. ... min.

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

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER

12. Name: Mack McClellan

13. Birthplace: unknown (City, town, or county) (State or foreign country)

14. Maiden name: Anna Grania

15. Birthplace: Kansana (City, town, or county) (State or foreign country)

16. (a) Informant: Samuel C. Smith

(b) Address: 4403 a Easton

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

(c) Place: burial or cremation: Jackson Ark

18. (a) Signature of funeral director: Sparger & Davis

(b) Address: 2734 Sheridan Ave

19. (a) MAY 14 1943 (Date received local registrar) J. T. Busick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12 year 1943 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from Apr 6, 1943 to Apr 12, 1943 that I last saw he alive on Apr 12, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia — Duration 1 day

Secondary Anemia 5 days

Due to: Hypertensive Vascular disease 6 mos

Due to:

Other conditions (Include pregnancy within 3 months of death): 32.4

Major findings:
Of operations:

Of autopsy:

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State)

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

23. Signature: Sean A. Smart (M. D. or other)

Address: 4069 a Easton Date signed 5/13/43

(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.....

Licensed Embalmer No. 3522

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.