

S. No. 2
DM-2-43
5-17-39
X38697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 9 1949 318

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 4922

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days
(Specify whether years, months or days)

In this community 55 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
17

(c) City or town St. Louis,
(If outside city or town limits, write "RURAL") 921

(d) Street No. 2025 Division
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Lee Smith

3. (b) If veteran, name war No

3. (c) Social Security No. 489-18-0851

4. Sex Male 5. Color or race col

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

6. (b) Name of husband or wife FRANCIS SMITH

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

7. Birth date of deceased Feb 24 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>2</u>	<u>29</u>	hr. min.

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

10. Usual occupation LABORER

11. Industry or business _____

MOTHER FATHER

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant Lyrraine Smith

(b) Address 3331 Delaware Blvd

17. (a) Burial (b) Date thereof 5-29-43
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wetheredickson

18. (a) Signature of funeral director Ernest Love

(b) Address 3103 Washington

19. (a) MAY 20 1949 (b) J. P. Brown
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23,
year 1943 hour 2 minute 05 P. M.

21. I hereby certify that I attended the deceased from May 2,
1943 to May 23, 1943
that I last saw him alive on May 23, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Hypertension with arteriosclerosis
Due to Cerebral Hemorrhage
Unk.
3 weeks

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

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? _____
(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

23. Signature J. E. Smith (M. D. or other) _____
Address 2601 Whittier Date signed 5/24/49

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

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..... *William Claude Gordon*

Licensed Embalmer No..... *3489*

P. O. Address..... *4575 Aldine*

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.