

FILED SEP 21 1943 318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **8145**

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:
4403 Olive St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **2yrs.** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Anna B Smith.**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **ISAAC A.** 6. (c) Age of husband or wife if alive **Decd** years

7. Birth date of deceased **Dec 23rd, 1863**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 **8** **20** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **At Home**

12. Name **Jacob Switzer**

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

14. Maiden name **Matilda Knapp**

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

16. (a) Informant **DALE W Alwood**

(b) Address **4403 Olive St**

17. (a) **Removal** (b) Date thereof **9/14/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Gibsonburg Ohio**

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

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

19. (a) **SEP 14 1943** (b) **J. H. Frederich**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4403 Olive St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **13th.**
year **1943** hour **4:30 AM.** minute _____ M.

21. I hereby certify that I attended the deceased from **Sept 10, 1943** to **Sept 13, 1943**
that I last saw him **or** alive on **Sept 11, 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **asthma** Duration **10 da**

Due to **myocarditis** **1 yr**

Due to _____

Other conditions (include pregnancy within 3 months of death) **7 1/2**

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 **W. H. Hopper** (M. D. or other) **MD**
Address **4500 Olive St** Date signed **9-13-43**

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

MOTHER FATHER

12-3
Wm. Nelson Smith
Fisher Block

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 J. Allen Klavin Jr.
Licensed Embalmer No. 4053
P. O. Address City

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.