

S. No. 2  
M-542  
V. 5-17-3  
X32873

30402

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. **8119**

Registration District No. **318**

Primary Registration District No. **1003**

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

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:  
**City Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution..... **0**  
(Specify whether)  
 In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County.....  
 (c) City or town..... **St. Louis**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **2923 Missouri Ave.**  
(If rural, give location)  
 (e) Citizen of foreign country?..... **No** (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME **John F. Smith**

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

Male **0** 5. **White** race  
 4. Sex.....  
 6. (b) Name of husband or wife..... **Cora**  
 6. (c) Age of husband or wife if alive.....  
 7. Birth date of deceased..... **April 1 1886**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** 11 day.....  
 year **1943** hour **5** min **30** P. M.

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

<b>55</b>	<b>57</b>	<b>5</b>	<b>10</b>	.....hr. ....min.
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*Cerebral Hemorrhage*

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

9. Birthplace..... **Collinsville Illinois**  
(City, town, or county) (State or foreign country)  
 10. Occupation..... **Chauffeur**  
 11. Industry or business..... **Beer Distributer**  
 12. Employer..... **Edward J. Smith**  
 13. Birthplace..... **Caseyville Illinois**  
(City, town, or county) (State or foreign country)  
 14. Maiden name..... **Lena Skala**  
 15. Birthplace..... **Collinsville Illinois**  
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings:  
 Of operations.....  
 Of autopsy.....  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant.....  
 (b) Address..... **4524a Chouteau Ave.**  
 17. (a) Burial (b) Date thereof..... **Sept. 14**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation..... **St. Peter & Paul Cem. Collinsville Illinois**  
 18. (a) Signature of funeral director..... **John H. Gibben**  
 (b) Address..... **2630 Gravois Ave.**  
 19. (a) SEP 13 1943 (b) *[Signature]*  
(Date received local registrar) (Registrar's signature)

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..... *[Signature]* (M, D. or other)  
 Address..... Date signed **9/13/43**

**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..... *Robert F. Gebken* .....

Licensed Embalmer No..... *4144* .....

P. O. Address..... *2630 Graves Ave* .....

**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.**

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

State of Missouri }  
County of St. Louis } ss.

State File No. ....

AFFIDAVIT FOR CORRECTION OF A RECORD

Local Registrar's No. 8119

On this 29th day of September, 1943, before me appears.....

Mr. Herman A. Gebken, who, upon his oath, states that the original record of ~~birth~~ death for John F. Smith ~~born~~ <sup>died</sup> Sept. 11th, 1943 in the State of Missouri, and which was filed at..... on....., 19....., should be corrected as follows:

Item No. 7 should read April 1, 1886

Instead of..... April 1, 1888

Item No. 8 should read 57 yrs. 5 mos. 10 days

Instead of..... 55 yrs. 5 mos. 10 days

Item No. .... should read.....

Instead of.....

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant Herman A. Gebken  
General Director Relationship.  
2636 Gravois Ave  
Present Address.

Subscribed and sworn to before me this 29 day of September, 1943

My Commission expires My Commission Expires March 4, 1945 John C. Paddock Notary Public.

*Cancelled  
9-29-43*

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

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