

FILED JAN 12 1944 318

Primary Registration District No. 1003

Registrar's No.

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:
1143 Hodiament Ave., Apt. B.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 11

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

(d) Street No. 1143 Hodiament Ave., Apt. B.
(If rural, give location)

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

3. (a) PRINT FULL NAME Ellen Smith.

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2
year 1944 hour 3.50 minute _____ A.M. M.

4. Sex Female / Color or race White

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

6. (b) Name of husband or wife John W. Smith

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

21. I hereby certify that I attended the deceased from Nov 20 - 1943 to Jan 2 1944
that I last saw her alive on Oct 31 1943
and that death occurred on the date and hour stated above.

7. Birth date of deceased April 1, 1876.
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death _____ Duration _____

Due to Ca of Cervix 1 1/2 yrs

Due to HB

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

10. Usual occupation Retired

Other conditions Cerebral Embolism 12 do.
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business _____

12. Name John Sullivan

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

14. Maiden name Catherine Hogan

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Miss. Mary F. Smith

(b) Address 1143 Hodiament Ave.,

17. (a) Burial (b) Date thereof Jan. 5/44.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.,

18. (a) Signature of funeral director Joe. W. Clark

(b) Address 1125 Hodiament Ave.,

19. (a) JAN 3 1944 (b) J. F. Mearns
(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)

(b) Means of injury _____

23. Signature Leo J. Keel (M. D. or other) _____
Address 810 S. Post Bld Date signed 1-3-44

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

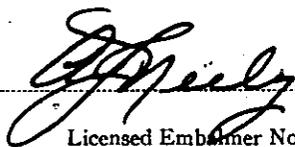
Dr. Leo Reilly,
8105 Page Blvd.,
Windfield 1021.
10.30 - 12 Noon

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. 3225

P. O. Address St. Louis, Mo.

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.