

FILED JAN 20 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **243**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute City Hosp. # 13
(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

3. (a) PRINT FULL NAME **Joseph Smith**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

4. Sex **male**
5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Ida Sarah Smith**
6. (c) Age of husband or wife if alive **(unk)** years
7. Birth date of deceased **April 30 1871**
(Month) (Day) (Year)

8. AGE: Years **72** Months **8** Days **9**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired**

11. Industry or business **Haberdasher**

12. Name **Meyer Smith**

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

14. Maiden name **Clara Burenstein**

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

16. (a) Informant **H. Darrish**

(b) Address **1152 Hamilton**

17. (a) **burial**
(Burial, cremation, or removal) (b) Date thereof **1/10/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Beth Ham Hag**

18. (a) Signature of funeral director **Berger Memorial**

(b) Address **4715 McPherson**

19. (a) **JAN 10 1944** (b) **J. F. Brader**
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **17**
(c) City or town **St. Louis** **75**
(If outside city or town limits, write "RURAL")
(d) Street No. **1152 Hamilton**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **9th**
year **1944** hour **12** minute **30** A. 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:
Crownary Sclerosis
Arterio Sclerosis
Duration _____
Due to _____
Due to _____

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)

Means of injury _____

23. Signature **Alfred Perry** (M. D. or other) _____

Date signed **1/10/44**

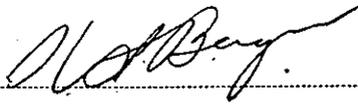
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

2
41
39
29484

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. 1597

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.