

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 15 1944

Registration District No. 277

Primary Registration District No. 6076

Registrar's No. 871

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town KOCH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ROBERT KOCH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 days
(Specify whether in this community years, months or days) same

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 4932 W. FLORISSANT
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME ROY SMITH

3. (b) If veteran, name war _____ 3. (c) Social Security No. 488-10-4739

4. Sex M 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife BERTHA BIEHL SMITH 6. (c) Age of husband or wife if alive UNKNOWN years
7. Birth date of deceased 6 - 3 - 03
(Month) (Day) (Year)

8. AGE: Years 40 Months 10 Days 5 If less than one day hr. min.

9. Birthplace OSAGE CO. MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation MAINTENANCE MAN

11. Industry or business ELEVATOR

12. Name STEPHEN SMITH

13. Birthplace OSAGE CO. MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name SARAH ROLLINS

15. Birthplace OSAGE CO. MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant PATIENT

(b) Address Removal

17. (a) (b) Date thereof 4-11-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Superior Mo

18. (a) Signature of funeral director J. V. Embry

(b) Address 3601 S Grand St.

19. (a) APR 12 1944 (b) E. G. McHarran, MD.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 8
year 1944 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from 3 - 17 1944 to 4 - 8 1944
that I last saw him alive on 4 - 8 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Lung Duration 9 mos (?)

Due to _____

Due to _____

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

Major findings: Carcinoma - Biopsy Of operations _____

Of autopsy 470

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 Edward S. Kach (M. D. or other) 4/9/44
Address Koch, MO. Date signed _____

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

600

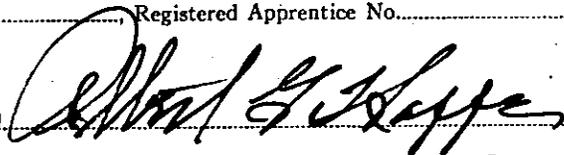
200752

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..... 2921

P. O. Address.....

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.