S. No. 2
M—8-43
. 5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 30 1944

Registration District No. 818

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 29800 8072

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:
Park Lane Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison

(c) City or town Granite City
(If outside city or town limits, write "RURAL")

(d) Street No. 2214 Madison Ave.
(If rural, give location)

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

NR

3. (a) PRINT FULL NAME Florence C. 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, married, widowed, divorced Widow

6. (b) Name of husband or wife H. B. Smith

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

7. Birth date of deceased December 25 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
77	8	25	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Unknown McCaleb

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

14. Maiden name Kate A. L. C. Duncan

15. Birthplace New Castle Delaware
(City, town, or county) (State or foreign country)

16. (a) Informant James L. Smith

(b) Address 2417 Benton, Granite City, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-21-44 (Month) (Day) (Year)

(c) Place: burial or cremation Granite City, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 20 1944 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 20 year 1944 hour 11:35 minute A. M.

21. I hereby certify that I attended the deceased from 8-1-44, 19..., to 9-20-44, 19...; that I last saw her alive on 9-20-44, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	
Due to: Chronic interstitial nephritis. Arterio-	
Due to: sclerosis.	
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) (e) Means of injury

23. Signature Frank J. Smith (M. D. or other) MD

Address 4930 Lindell, St. Louis Date signed 9-20-4

(Licensed Embalmer's Statement on Reverse Side)

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 John Agonosh

Licensed Embalmer No. 3398

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.