

Registration District No. **317**

Primary Registration District No. **6076**

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

1. PLACE OF DEATH:
 (a) County **ST. LOUIS**
 (b) City or town **MANCHESTER**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
MANCHESTER NURSING HOME
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **9 months 4**
(Specify whether
 In this community **9 months**
years, months or days)

3. (a) PRINT FULL NAME **NANCY 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, widowed, married, divorced **Single**
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive **4** years
 7. Birth date of deceased **DEC- 4- 1943**
(Month) (Day) (Year)

8. AGE: Years **0** Months **9** Days **20**
If less than one day
 hr. min.

9. Birthplace **St. Louis, Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business

MOTHER FATHER

12. Name **CRAIG M. SMITH**

13. Birthplace **CRASTON RHODE ISLAND**
(City, town, or county) (State or foreign country)

14. Maiden name **B. V. B. N.**

15. Birthplace **S. KINGSTON R. I. RHODE ISLAND**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Josephine Huber**

(b) Address **Manchester, Mo.**

17. (a) Burial **(b) Date thereof** **Sept. 25-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **M.E. Cem. Ballwin, Mo.**

18. (a) Signature of funeral director **debeater funeral home**

(b) Address **Ballwin, Mo.**

19. (a) SEP 26 1944 **(b) C. D. McFarlan, M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **ST. LOUIS**
 (c) City or town **WEBSTER GROVES - 91**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1023 So. Colwell**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

22. DATE OF DEATH: Month **Sept.** day **24**
 year **1944** hour **10** minute **2** M.
21. I hereby certify that I attended the deceased from **Dec 14**
1943, to **Sept 24**, **1944**;
 that I last saw her alive on **Sept 21**, **1944**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **coronatal heart disease**
 Duration

Due to **myocardial infarct**

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
 Of operations **192**
 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?
(Specify type of place)

While at work? (c) Means of injury

23. Signature **A. J. Merklein** (M. D. or ~~other~~)

Address **2507 Patomas** **Date signed** **9-29-44**

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.

This body is not embalmed

Signed.....

Licensed Embalmer No.....

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.