

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

FILED DEC 27 1944

Registration District No. **318**

Primary Registration District No. **1002**

Registrar's No. **10641**

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:
4209 Lindell Blvd.
(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 **Louisa Smith**

3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **Unknown**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Louis Smith** 6. (c) Age of husband or wife if alive **Unk.** years

7. Birth date of deceased **March 31 1875**
(Month) (Day) (Year)

8. AGE: Years **69** Months **8** Days **10** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John M. Thorp**

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

14. Maiden name **Jane Zeeder**

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

16. (a) Informant **Mrs. J.M. Whitehead**
(b) Address **Janesville, Wis.**

17. (a) **Removal** (b) Date thereof **12-13-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Madison, Wisconsin**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**

19. (a) **DEC 13 1944** (b) **J. J. Bredeh**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **New York** (b) County **999**
(c) City or town **New York City** **30**
(If outside city or town limits, write "RURAL")
(d) Street No. **Unknown**
(If rural, give location)
(e) Citizen of foreign country? **No**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **11**
year **1944** hour **4** minute **58 P.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to **Apoplexy**
Due to **83 ad**
Other conditions (Include pregnancy within 3 months of death) _____

Duration

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)
(c) Means of injury **5**
23. Signature **Patrol E. J. ...** (M. D. or other)
Address _____ Date signed **12/13/44**

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.

Signed.....

Albert G. Happe

Licensed Embalmer No..... *2971*.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County _____
- (b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: _____
(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 Louisa M. Smith

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased. (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name Jane Veeder

15. Birthplace Rotterdam, New York
(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 1-8-45 (b) J. H. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MO.
- (b) County _____
- (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
- (d) Street No. _____
(If rural, give location)
- (e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 12 day 11
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ 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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

1944
S-39808