

State File No. _____

FILED FEB 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **812**

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:
#20 Portland Place
(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

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. **#20 Portland Place**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Emilie Francis**

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

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

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

7. Birth date of deceased: **Unk. Unk. 1878**
(Month) (Day) (Year)

8. AGE: Years **66** Months **Unk.** Days **Unk.** If less than one day _____ hr. _____ min.

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

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Dr. Elsworth Smith**

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

14. Maiden name **ISABELLE Chenfe Smith**

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

16. (a) Informant **Mr. J. Sheppard Smith Jr.**

(b) Address **#20 Portland Place**

17. (a) **Burial** (b) Date thereof **1-27-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Lindell Blvd.**

19. (a) **JAN 29 1945** (b) **J. F. Bredbeck**
(Date received local report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **25th.**,
year **1945** hour **11** minute **20** p.m.

21. I hereby certify that I attended the deceased from **July 24**, 19**42**, to **Jan. 25**, 19**45**;
that I last saw her alive on **Jan. 25**, 19**45**;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocarditis, Chr. Degeneration** Duration **3 yrs.**

Due to **General Arterio Sclerosis**

Due to **Arterial Hypertension**

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **Hiram L. Tuggett** (M. D. or other) **M.D.**
Address **3720 Washington Blvd** Date signed **1/26/45**

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

MOTHER FATHER

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 W. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.