

FILED JAN 31 1945

318

1003

Registration District No.

Primary Registration District No.

Registrar's No.

630

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

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town MO. ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Missouri Baptist Hosp.
(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)

3. (a) PRINT FULL NAME LOUISE SMILEY

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 M.
6. (b) Name of husband or wife FREDERICK 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased SEPT 1 1876
(Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days 19 If less than one day hr. min.

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

10. Usual occupation HOUSE WORK.

11. Industry or business SELF.

MOTHER FATHER { 12. Name DONT KNOW

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

14. Maiden name DONT KNOW

15. Birthplace DONT KNOW (City, town, or county) (State or foreign country)

16. (a) Informant George Smiley

(b) Address U.S. Navy

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-45 (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK.

18. (a) Signature of funeral director Proctor and Co.

(b) Address 3710 N. Grand Ave.

19. (a) JAN 22 1945 (Date recorded by registrar) J. F. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County MO.
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")
(d) Street No. 4618 SAN FRANCISCO (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month January day 20 year 1945 hour 1:30 minute 0 P.M.

21. I hereby certify that I attended the deceased from Jan 6, 1945 to Jan 20, 1945
that I last saw h. or alive on Jan 20, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage left Duration 10 days
Due to Essential Hypertension yrs.

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 Harold C. McCann (M. D. or other) M.D.
Address 3220 Washington Date signed 1-22-45

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 Earl E. Provost

Licensed Embalmer No. 1528

P. O. Address 3710 9th Island

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.