

No. 2
4-5-43
5-17-39
1 X36671

FILED MAY 12 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

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:
2730th S. 59th St. 1
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2730th S. 59th St. 1
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME James A. Smith

3. (b) If veteran, name war 770

3. (c) Social Security No. 770

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sophie Smith

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased March 30 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>0</u>	<u>27</u>	hr. _____ min. _____

9. Birthplace Harrisonville Ill. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Bookkeeper

11. Industry or business _____

12. Name Unknown Smith

13. Birthplace Illinois 1
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Sophie Smith

(b) Address 2730th S. 59th St.

17. (a) Burial (b) Date thereof 4-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cem.

18. (a) Signature of funeral director With Bro. Kille

(b) Address 2929 S. Jefferson Av.

19. (a) APR 29 1945 (b) J. F. Bredsch
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 27
year 1945 hour 7 minute 30 p. M.

21. I hereby certify that I attended the deceased from Mar. 24 1944 to Apr. 27 1945
that I last saw him alive on Apr. 27 1945
and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA of Prostate 145

Duration _____

Due to _____

Due to _____

Other conditions CHRONIC MYOCARDIIS ?
(Include pregnancy within 3 months of death)

ARTERIOSCLEROSIS GENERAL

Major findings: Carcinoma of prostate

Of operations Feb 1945

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 H. J. Couillard (M.D. or other) M.D.
Address 5930 Southwest Ave Date signed 4-29-45

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.....

John P. Fetter

Licensed Embalmer No. 3880

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.