S. No. 2
M—8-43
r. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14618

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 821

1. PLACE OF DEATH:
(a) County ~~St. Louis~~ Rural Hellston
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Vincent's Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 mos 15 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Richland
(c) City or town Olney
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mrs. Cora L. Smith
3. (b) If veteran, name war Nil
3. (c) Social Security No. None
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 2 (Day) 1865 (Year)

8. AGE: Years 79 Months 9 Days 0 If less than one day hr. min.

9. Birthplace New York (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name John Moore
13. Birthplace New York (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Adelaide Vrowan
15. Birthplace New York (City, town, or county) (State or foreign country)
16. (a) Informant James Germer
(b) Address Olney, Illinois
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-2-45 (Month) (Day) (Year)
(c) Place: burial or cremation Olney, Illinois
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) APR 3 1945 (Date received local registrar) (b) C. G. McGavran (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 2 year 1945 hour 1:10 minute A. M.
21. I hereby certify that I attended the deceased from OCTOBER 17, 1944, to APRIL 2, 1945; that I last saw her alive on APRIL 2, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death MYOCARDIAL FAILURE	1 WEEK
Due to GENERALIZED ARTERIOSCLEROSIS	5 YRS.
Due to	
Other conditions SENILE PSYCHOSIS (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 93.1

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 P. E. Kutitschek (M. D. or other) M.D.
Address ST. VINCENT'S SAN. Date signed 4-2-45

(Licensed Embalmer's Statement on Reverse Side)

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 G W Wilkinson

Licensed Embalmer No. 3575

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.