

7. S. No. 2
00M-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19218**
Registrar's No. **5106**

FILED JUN 8 1945

1003

Registration District No. _____ Primary Registration District No. _____

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: DePaul Hospital **6**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
(Specify whether in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17 9
(If outside city or town limits, write "RURAL")
(d) Street No. 1915a Ferry Str.
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Catherine Smith

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female! 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Paul Smith 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 8, 1871
(Month) (Day) (Year)

8. AGE: Years 74 Months 1 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Timothy Costello

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

14. Maiden name Unknown

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

16. (a) Informant Claud M. Smith

(b) Address 1915a Ferry Str.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/45 (Day) (Year)

(c) Place: burial or cremation St. Charles Mo

18. (a) Signature of funeral director _____

(b) Address 2117 E. Grand Blvd.

19. (a) 6-10-45 (Date received local registrar) (b) J. F. Brudeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8 year 1945 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 10, 1945, to June 8, 1945; that I last saw her alive on June 8, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral of liver Site primary tumor not determined Duration 3 mo

Due to _____

Due to _____

Other conditions Hypertensive heart disease (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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. H. Feller MD (M. D. or other)
Address 2802 N. Grand Date signed 6-9-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address: 2117 E Grand

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.