

S. No. 2
DM-543
v. 5-17-39
I X36871

26152

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 1 1945
Registration District No. **818**

Primary Registration District No. **1003**

Registrar's No. **7216**

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3929 Delmar Avenue /
(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)

3. (a) PRINT FULL NAME JOHN B. SMITH

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

4. Sex Male / 5. Color or race White

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

6. (b) Name of husband or wife Laura Smith
 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased December 2, 1882
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>62</u>	<u>8</u>	<u>15</u>	hr. _____ min.

9. Birthplace Maryetta, Ohio. /
(City, town, or county) (State or foreign country)

10. Usual occupation Coal Handler

11. Industry or business.....

MOTHER FATHER { 12. Name James A. Smith

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

14. Maiden name Mary Jane Moore

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

16. (a) Informant Laura Smith
 (b) Address 3929 Delmar Ave.

17. (a) Burial (b) Date thereof 8/18/45
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Gebken-Benz

(b) Address 2842 Meramec Street.

19. (a) AUG 18 1945 (b) J. J. Breese
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 3929 Delmar /
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 2

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17th.
 year 1945 hour 5.45 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Myocarditis
Physical Effusion
Pituitary Adenoma

Due to.....
 Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....
 Of autopsy.....

Duration
 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? _____ (e) Means of injury.....
 23. Signature Alfred J. Kelly (M. D. or other) 3
 Address Delmar Date signed 8/18/45

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

Ronald Yalmer

Licensed Embalmer No.

3917

P. O. Address

OT Harris Mo

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.