

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

FILED OCT 31 1945

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No. 8408

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Barnes Hospital... 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days.
(Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois. (b) County Warren, 909

(c) City or town R.F.D. Monmouth,
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Waller Francis Smith.

3. (b) If veteran, name war none.

3. (c) Social Security No. none.

4. Sex Male. 0

5. Color or race White.

6. (a) Single, widowed, married, divorced Single. 0

6. (b) Name of husband or wife

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

7. Birth date of deceased November 20, 1925.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
19	10.	7.	hr. min.

9. Birthplace Warren County, Illinois.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Spt day 27
year 1945 hour 6 minute 20 M.

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

Immediate cause of death Injury of skull
subdural hemorrhage of
brain when he lost control
of the motorcycle he was
riding on highway #43 between
Campee Hill and Wilcoxville
Illinois 11:10 A.M. Sept 22nd
1945

Other conditions
(Include pregnancy within 3 months of death)

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident

(b) Date of occurrence Sept 27 1945 1:36

(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?
Public highway

While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter E. Smith (M. D. or other)
Address Key St Date signed 9/27/45

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

MOTHER FATHER

11. Industry or business

12. Name Gilbert Smith.

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

14. Maiden name Effie Gardner.

15. Birthplace Warren County, Illinois.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Effie Smith.

(b) Address Monmouth, Ill.,

17. (a) Removal. (b) Date thereof 9/28/45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Monmouth, Ill.,

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Bly'd.

19. (a) SEP 28 1945 (b) J. F. Bridgch
(Date received local registrar) (Registrar's signature)

NOV 5 1947

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 Carroll A. Murray
Licensed Embalmer No. 4011
P. O. Address St. Louis, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29398

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Walker F. Smith

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov - 20 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 7
year 1945 hour _____ minute 15-8 M.

21. I hereby certify that I attended the deceased from _____ 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 Fracture of Skull
Abdominal hemorrhage of brain
when he lost control of the
motorcycle he was riding
on highway #43 between
Campbell Mills and Wilberville
Illinois 11.56. m Sept. 22 1945

Other conditions None
(Hemiplegia, paraplegia, or other permanent defects)

Major findings: new collision - lost control
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) Accident
(b) Date of occurrence Sept 22 1945
(c) Where did injury occur? St Louis Mo (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 Motorcycle

23. Signature Robert C. Dyer (M. D. or other) _____

Address _____ Date signed 11/22/45

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

SUPPLEMENTARY

more

1945

5-29398