

U.S. No. 2
FORM-5-43
REV. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35869
Registrar's No. 9583

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, Mo.
(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 6531 St. Park 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 79 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 6531 St. Park (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William B. Smith
3. (b) If veteran, name war no 3. (c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month NOV. day SAT. 3rd
year 1945 hour 4:45 minute _____ P. M.
21. I hereby certify that I attended the deceased from June 18
1940 to Nov. 3 1945
that I last saw him alive on Nov. 3 1945
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Margaret 6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased Dec. 18, 1865 (Month) (Day) (Year)

Immediate cause of death Chronic Interstitial Nephritis Duration 2 years
Due to arteriosclerosis
Due to Hypertension N
Other conditions (Include pregnancy within 3 months of death) 121

8. AGE: Years Months Days If less than one day
79 10 17 hr. _____ min. _____
9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Hotel Keeper
11. Industry or business Grocery Store
12. Name James Smith
13. Birthplace Don't know (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Greer
15. Birthplace Don't know (City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Inrigares Smith
(b) Address 6531 St. Park
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peter's Cemetery
18. (a) Signature of funeral director Joseph A. Dewant
(b) Address 1619 1/2 1st St.
19. (a) NOV 5 1945 (Date of local registrar) J. F. Bredeck (Registrar's signature)

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) (e) Means of injury _____
23. Signature J. O. Herfurth (M. D. or other) 10/5/45
Address 2000 S. Brentwood Date signed _____

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.....

Joe A. Howard

Licensed Embalmer No. *3941*

P. O. Address: *4212 St Louis Ave*

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.