

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED DEC 8 1945 STANDARD CERTIFICATE OF DEATH

State File No. **36840**

Registration District No. **53**

Primary Registration District No. **3010**

Registrar's No. **363**

1. PLACE OF DEATH:
 (a) County **CAPE GIRARDEAU**
 (b) City or town **CAPE GIRARDEAU**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **St. Francis Hosp.**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. **4 Hrs**
 In this community. **4 Hrs**
 years, months or days

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

3. (a) PRINT FULL NAME **Baby Smith**
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **Female** **5. Color or race** **3 Negro**
6. (a) Single, widowed, married, divorced **child**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **+**
7. Birth date of deceased **Nov 1 1945**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 hr. **30** min.

9. Birthplace **CAPE GIRARDEAU Mo**
 (City, town, or county) (State or foreign country)
10. Usual occupation **child**

11. Industry or business
12. Name **Unknown**
13. Birthplace **Unknown Unknown**
 (City, town, or county) (State or foreign country)
14. Maiden name **Frene Smith**
15. Birthplace **Senath Mo**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mose Smith**
(b) Address **Wardell, Mo**

17. (a) Burial (b) Date thereof **11-5-45**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Wardell, Mo**

18. (a) Signature of funeral director **Delisle Funeral Parlor**
(b) Address **Paragon, Mo**
19. (a) 11-10-45 (b) **C. G. Summers**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov** day **4**
 year **1945** hour **2** minute **23 A.M.**
21. I hereby certify that I attended the deceased from **11/4**
1945 to **11/4** **1945**
 that I last saw h.e.r. alive on **11/4** **1945**
 and that death occurred on the date and hour stated above.

Immediate cause of death. **Jeremia - Due to 1st eclamptic conv. of males**
 Due to
 Due to
 Other conditions. (Include pregnancy within 3 months of death)
 Major findings: Of operations
 Of autopsy **16/10**

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? (Specify type of place) (e) Means of injury **0**
23. Signature **D B Eldred** (M. D. or other)
 Address **714 Broadway Cape Gir, Mo** Date signed **11/9/45**

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

16
14

1569

(Licensed Embalmer's Statement on Reverse Side)

District No. 4
District File Number 1245-13
Date Filed 12-6-45

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.....

Licensed Embalmer No.....

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.

No Embalming