S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 26 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38627

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2639

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 28 days (Specify whether years, months or days)
In this community See above

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Saint Clair 999
(c) City or town East St. Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. Bet. 16th&17th on Division Street 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME SMITH, Clarence
3. (b) If veteran, name war World I
3. (c) Social Security No. 355-01-2905
4. Sex Male 2
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widower 3
6. (b) Name of husband or wife ---
6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased September (Month) 18 (Day) 1896 (Year)

8. AGE: Years 49 Months 2 Days 2 If less than one day hr. min.

9. Birthplace Malvern (City, town, or county) Arkansas 1 (State or foreign country)
10. Usual occupation Laborer
11. Industry or business --
FATHER
12. Name John Smith
13. Birthplace (City, town, or county) Arkansas 1 (State or foreign country)
MOTHER
14. Maiden name Nellie Dennis
15. Birthplace (City, town, or county) Arkansas 1 (State or foreign country)
16. (a) Informant Clinical Clerk, Vet. Adm. Hosp.
(b) Address Jefferson Barracks, Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-21-45 (Month) (Day) (Year)
(c) Place: burial or cremation Malvern, Arkansas
18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.
19. (a) 11-23-45 (Date received local registrar) (b) E G McGann MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 20th year 1945 hour 7:15 minute A. M.
21. I hereby certify that I attended the deceased from October 23, 1945 to November 20, 1945; that I last saw him alive on November 20, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
EMPYEMA, RIGHT due to	
LOBAR PNEUMONIA, RIGHT LOWER AND	
MIDDLE LOBE.	3 Months
Due to --	
Due to --	
Other conditions -- (Include pregnancy within 3 months of death)	

Major findings:
Of operations No operation
Of autopsy No 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) No
(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)
While at work (e) Means of injury
23. Signature R. V. EDWARDS, Lt. Col., (M. D. or other) M.C., Clinical Director.
Address Vet. Adm. Hosp. Jeff. Brks. Mo. Date signed 11/20/45

(Licensed Embalmer's Statement on Reverse Side)

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

Thomas J. Gates, Registered Apprentice No.

working under my personal supervision.

Signed Thomas J. Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney 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.