

FILED APR 18 1946

Registration District No. _____ Primary Registration District No. **100**

1. PLACE OF DEATH: **318**

(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:
enroute to City Hospital 3
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community **46 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
 (c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
 (d) Street No. **826 N. 6th. St.** **259**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) **0**
 If yes, name country _____

3. (a) PRINT FULL NAME **John Joseph Smith**

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

3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **Divorced 3**

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

7. Birth date of deceased **October 14th 1899**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

46 **5** **21** hr. min.

9. Birthplace **St. Louis Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **William B. Smith**

13. Birthplace **St. Louis Mo. 0**
(City, town, or county) (State or foreign country)

14. Maiden name **Lillian Johnstone**

15. Birthplace **St. Louis Mo. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edward J. Smith**

(b) Address **4009 Fair view Ave.**

17. (a) **Burial** (b) Date thereof **4-9-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Hy. Leidner U. Co.**

(b) Address **2223 St. Louis Ave.**

19. (a) **APR 8 1946** (b) **J. F. Bredet**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **5th.**
 year **1946** hour **5:07 PM** minute **258** 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 _____ *Duration*

Coronary Occlusion

Coronary Sclerosis

Due to _____

Due to _____

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

Major findings: _____

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) _____

(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)

23. Signature **Patrick E. Taylor, Dep. Cor** (City, town, or county) **3**
 Address **1300 Clark** Date **4-8-46**

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

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 John P. Buchholz
Licensed Embalmer No. 1674
P. O. Address 2223 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.