S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

23802

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 30 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24951

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1523

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town KOCH (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 252 DAYS (Specify whether years, months or days)

In this community 252 DAYS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County —

(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")

(d) Street No. 615 WALNUT (If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME HARRY WILLIS SMITH

3. (b) If veteran, name war

3. (c) Social Security No. 490-22-0493

4. Sex M O

5. Color or race W

6. (a) Single, widowed, married, divorced 3 DIVORCED

6. (b) Name of husband or wife —

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

7. Birth date of deceased 10 (Month) 19 (Day) 1892 (Year)

8. AGE: Years 53 Months 9 Days 0 If less than one day hr. min.

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

10. Usual occupation DISHWASHER

11. Industry or business —

FATHER
12. Name WILLIAM SMITH
13. Birthplace JACKSON (City, town, or county) MO. (State or foreign country)

MOTHER
14. Maiden name MARY WILLIAMS
15. Birthplace JACKSON (City, town, or county) MO. (State or foreign country)

16. (a) Informant HOSPITAL RECORD

(b) Address ROBT KOCH HOSP, KOCH, MO.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 7-19-1946 (Month) (Day) (Year)

(c) Place: burial or cremation CAPE GIRARDEAU MO.

18. (a) Signature of funeral director HOWARD F. ROWLAND

(b) Address 4865 WASHINGTON AV.

19. (a) 7-20-46 (Date received local registrar) (b) C. G. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 19 year 1946 hour 2 minute 03 A.M.

21. I hereby certify that I attended the deceased from ~~11/19~~ 11/9, 1945, to 7/19, 1946; that I last saw him alive on 7/19, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death PULMONARY TUBERCULOSIS	?
Due to	
Due to 13	
Other conditions (Include pregnancy within 3 months of death) TUBERCULOUS ENTERITIS	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature David Feldman (M. D. or other) MD

Address ROBT KOCH HOSP. KOCH, MO. Date signed 7/19/1946

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed John Kettler

Licensed Embalmer No. 3880

[redacted] 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.