

S. No. 2
M-2-43
5-17-39
X3567

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 22 1946
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **25740**
Registrar's No. **6111**

1. PLACE OF DEATH:
(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:
5845 Etzel Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or 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. **5845 Etzel Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **10th**
year **1946** hour **6:** minute **40** A.M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **September 29, 1869**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Dec 10**, 19**44**, to **July 10**, 19**46**
that I last saw her alive on **July 10**, 19**46**
and that death occurred on the date and hour stated above.

8. AGE: Years **76** Months **9** Days **11** If less than one day _____ hr. _____ min.

Immediate cause of death: **Coronary Occlusion**
Duration **2 hours**

9. Birthplace: **Franklin Co. Missouri**
(City, town, or county) (State or foreign country)

Due to: **Arteriosclerotic Heart Disease**
Due to _____

10. Usual occupation: **At Home**

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

11. Industry or business _____

Major findings: _____
Of operations _____
Of autopsy _____

12. Name: **Lawrence Smith**

13. Birthplace: **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name: **Mary Clays**

15. Birthplace: **Penn**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Margaret Smith**

(b) Address: **5845 Etzel Ave.**

17. (a) **Burial** (b) Date thereof: **7 -13 -46**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director: **J. F. Brundage**

(b) Address: **177 Union St.**

19. (a) **JUL 11 1946** (b) **J. F. Brundage**
(Date received local registrar) (Registrar's signature)

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 _____

23. Signature: **G. O. Brown** (M. D. or other) **D. M. D.**

Address: **1325 S. Grand** Date signed: **7/10/46**

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

MOTHER FATHER

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..... *Henry M. Brammer*

Licensed Embalmer No..... *4200*

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.