

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

Registration District No. 318

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 days  
(Specify whether years, months or days)  
In this community \_\_\_\_\_

3. (a) PRINT FULL NAME Cora Smith  
3. (b) If veteran, name war ---  
3. (c) Social Security No. None

4. Sex Female  
5. Color or race Negro  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Sylvester Smith  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased Aug. 29 1885  
(Month) (Day) (Year)

8. AGE: Years 61 Months 1 Days 16  
If less than one day hr. min.

9. Birthplace Collinsville Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ---

MOTHER FATHER

12. Name Alonzo Mitchell

13. Birthplace Waterloo Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Maryanna Walker

15. Birthplace Pike Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Sylvester Smith  
(b) Address 1907a Whittier St.

17. (a) Burial (b) Date thereof 10/19/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates  
(b) Address 4107 Finney Ave.

19. (a) OCT 16 1946 (b) J. F. Moseley  
(Date received local registrar) (Registrar's signature)

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. 1907 Whittier  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15  
year 1946 hour 10 minute X A M.

21. I hereby certify that I attended the deceased from 10-7 1946 to 10-15 1946;  
that I last saw her alive on Oct. 15 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease with Decompensation; Arterolar Nephro-  
sclerosis  
Duration Undet.

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy No  
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 E. B. Williams (M. D. or other)  
Address 2601 n Whittier Date signed 10/16/46

**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*  
.....  
working under my personal supervision.

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

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.**