

No. 2
-12-45
5-17-39
I X47070

FILED JAN 27 1947
Registration District No. **378**

Primary Registration District No. **100**

Registrar's No. **344**

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:
Infirmiry. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: **6/15/46 to 1/9/47**
(Specify whether years, months or days)

In this community.....
years, months or days

3. (a) PRINT FULL NAME..... **MAGGIE SMITH**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female	5. Color or race Col	6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife.....	6. (c) Age of husband or wife if alive..... years	
7. Birth date of deceased..... ?	?	1876
<small>(Month)</small>	<small>(Day)</small>	<small>(Year)</small>

8. AGE:	Years	Months	Days	If less than one day
70	?	?		hr. min.

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

10. Usual occupation..... **Nil**

11. Industry or business.....

MOTHER FATHER

12. Name..... **Unknown**

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

14. Maiden name..... **Unknown**

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

16. (a) Informant..... **City Infirmiry Records**

(b) Address..... **5800 Arsenal St**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof..... **1-13-47**
(Month) (Day) (Year)

(c) Place: burial or cremation..... **GREEN WOOD**

18. (a) Signature of funeral director..... **Berna Lane**
 (b) Address..... **3103 WASHINGTON**

19. (a) **JAN 13 1947** (Date received local registrar) (b) **J. J. Breder** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County..... **000**

(c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No..... **3509 Clark Ave.**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) **0**
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **9**
 year **1947** hour **6** minute **00** P.M.

21. I hereby certify that I attended the deceased from **7/2/45**
 1/9 19 47

that I last saw her alive on **January 9** 19 47
 and that death occurred on the date and hour stated above.

Immediate cause of death..... **Pulmonary Edema** Duration **2 Days**

Due to **Chronic Myocarditis 1946** Plus

Pyelonephritis with Cyst (right)
 Duration unknown

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) (e) Means of injury.....

23. Signature..... **Palma Prussia Bowlich** (M. D. or other) **0**

Address..... **City Infirmiry** Date signed..... **1/9/47**

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.....

W. Claude Gordon

Licensed Embalmer No. *3487*

P. O. Address *4575 Aldine*

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.