

FILED MAR 31 1947

Registration District No.

318

Primary Registration District No.

2860

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... 4 Days
(Specify whether
In this community..... 50 Years
years, months or days)

3. (a) PRINT FULL NAME..... CARRIE MAITLAND

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

4. Sex..... F. / 5. Color or race..... W.
6. (a) Single, widowed, married, divorced..... Divorced

6. (b) Name of husband or wife..... Hugh Maitland
6. (c) Age of husband or wife if alive..... 79 years

7. Birth date of deceased..... October 30, 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 4 15 hr. min.

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

10. Usual occupation..... At Home

11. Industry or business.....

MOTHER FATHER { 12. Name..... Henry Clay Smith 9
13. Birthplace..... Unknown
(City, town, or county) (State or foreign country)
14. Maiden name..... Miriam Higgins
15. Birthplace..... Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant..... Hugh Maitland
(b) Address..... 2609a Olive Street

17. (a) Burial (b) Date thereof..... 3-18-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... St. Peters Cemetery

18. (a) Signature of funeral director..... Arthur J. Donnell

(b) Address..... 3840 Ridge Road

19. (a) MAR 18 1947 (b) J. H. Brecken
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo. (b) County..... 2 boe
(c) City or town..... St. Louis 17
(If outside city or town limits, write "RURAL") 90
(d) Street No..... 2609a Olive Street
Memorial (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... March day..... 15th
year..... 1947 hour..... 7:30 minute..... P M.

21. I hereby certify that I attended the deceased from..... 3/12/47
19..... to..... 3/15/47 19.....
that I last saw her alive on..... 3/15/47 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Hypertensive Cardiovascular Disease 10 yrs

Due to.....
Chronic Glomerulonephritis 10+ yrs

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) (f) Means of injury.....

19. (a) Signature..... Borgy B... 0
(b) Address..... (c) Date signed.....

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 Van Matre

Licensed Embalmer No. 2825

P. O. Address. 4340 Lafayette

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.