

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF HEALTH  
BUREAU OF THE CENSUS  
FILED MAR 24 1947  
318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11554  
State File No. \_\_\_\_\_  
Registrar's No. 2503

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

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:  
3738a So. Broadway  
(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 oao  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3738a So. Broadway  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Smith  
3. (b) If veteran, name war World War 1  
3. (c) Social Security No. 499-01-3025  
4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Girtha  
6. (c) Age of husband or wife if alive 36 years  
7. Birth date of deceased October 1 1895  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 7th  
year 1947 hour 4 minute 45 P. M.  
21. I hereby certify that I attended the deceased from:  
Mar. 6th 1947 to March 7 1947  
that I last saw him alive on March 7 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
51 5 6 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death  
Robert Pneumonia  
Duration 4 days  
Due to \_\_\_\_\_  
Due to 108  
Chronic Bronchitis  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation Vender  
11. Industry or business \_\_\_\_\_  
12. Name Charles Smith  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Bertha Mueller  
15. Birthplace Unknown.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Girtha Smith  
(b) Address 3738a So. Broadway  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11, 1947  
(Month) (Day) (Year)  
(c) Place: burial or cremation Jefferson Barracks, Mo.  
18. (a) Signature of funeral director Gebken-Benz Mortuary  
(b) Address 2842 Moramec St.  
19. (a) MAR 10 1947 (Date received local registrar) (b) \_\_\_\_\_ (Registrar's signature)

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) Manner of injury \_\_\_\_\_  
23. Signature Levin J. Gault (M. D. or other) \_\_\_\_\_  
Address 3407 1/2 Jefferson Date signed 3-10-47

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

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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.....

*Joe S. Benz*  
Licensed Embalmer No. 4249  
2842 Meramec St.  
P. O. Address..... St. Louis, Missouri. 18.

**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.**