

FILED APR 8 1947
#83524

State File No. _____

Registration District No. **318**

Primary Registration District No. **1002**

Registrar's No. _____

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 2 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME JAMES SMITH

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Unk.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 17th, ?
(Month) (Day) (Year)

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

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

10. Usual occupation OAA

11. Industry or business _____

12. Name William Smith 9

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

14. Maiden name Mary Unk. 9

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Anatomical Board
(b) Date thereof 3-21-47
(Month) (Day) (Year)

(c) Place: burial or cremation Washington
18. (a) Signature of funeral director W. Richter
(b) Address 3500 Bicknell
19. (a) MAR 28 1947 (b) J. F. Brubaker
(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. Memorial 808 S. 3rd St.
(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 14th
year 1947 hour 4:20 minute P M.

21. I hereby certify that I attended the deceased from 3/12/47
to 3/14/47, 19____; that I last saw him alive on 3/14/47, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 2 days
Due to Astoria - Sclerotic +
My pericardial Heart Disease 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 _____

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) (c) Means of injury _____

23. Signature 1515 Lafayette 3/15/47
Address Joe H. Harless Date signed _____
(M. D. or other)

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.....

Licensed Embalmer No.....

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.