

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

19377

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 22 1947 318

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 4821

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:
Homer G. Phillips
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days)

In this community _____
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County San

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

(d) Street No. 2029 Carr
21 (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Etta Louise Smith

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro

6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Nov 27 1906
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>5</u>	<u>13</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name Ineda Smith

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

16. (a) Informant E. M. Sherrard R. R. / Dival

(b) Address 2601 N. Whittier

17. (a) _____ (b) Date thereof 5-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washing In Park

18. (a) Signature of funeral director D. Richardson

(b) Address 2625 Glasgow

19. (a) MAY 13 1947 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 10
year 1947 hour 8 minute 30 M.

21. I hereby certify that I attended the deceased from 5-6-
_____ 1947 to 5-1- _____ 1947
that I last saw her alive on 5-10 _____ 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Diarrhea Duration _____

Due to _____

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? _____

(Specify type of place) _____

While at work? _____ Means of injury _____

23. Signature Thodore Blum (M. D. or other) _____
Address 2601 N. Whittier Date of cert. 5-12-47

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

A. D. Richardson

Licensed Embalmer No. *2928*

P. O. Address *City*

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.