S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 12 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22661

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6449

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: 5639 WELLS AV. 1 (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 Mo. (b) County 000
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 17
(d) Street No. 5639 Wells av (If rural, give location) 9
(e) Citizen of foreign country? (Yes or No) 6
If yes, name country

3. (a) PRINT FULL NAME WILLIAM E. SMITH
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex MALE
5. Color or race W
6. (a) ~~Single~~, ~~widowed~~, married, ~~divorced~~ M. 1
6. (b) Name of husband or wife ELLEN SMITH
6. (c) Age of husband or wife if alive years
7. Birth date of deceased FEB. (Month) 4 (Day) 1875 (Year)

8. AGE: Years 72 Months 5 Days 2 If less than one day hr. min.

9. Birthplace ST. LOUIS (City, town, or county) Mo. (State or foreign country)
10. Usual occupation NIL.
11. Industry or business
FATHER
12. Name UNKNOWN SMITH
13. Birthplace UNK. (City, town, or county) UNK. (State or foreign country) 9
MOTHER
14. Maiden name unk unk
15. Birthplace unk (City, town, or county) unk (State or foreign country) 9
16. (a) Informant Mrs Ellen Smith
(b) Address 3659 Wells av
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 9 (Month) (Day) 47 (Year)
(c) Place: burial ~~or cremation~~ VALHALLA CEM.
18. (a) Signature of funeral director E. J. Sohnur
(b) Address 3125 Lafayette av
19. (a) JUL 8 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1947 hour 3 minute 30 A. M.
21. I hereby certify that I attended the deceased from 1938 to July 6 1947 that I last saw him alive on July 5 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Sept Hemiplegia
Due to Arterio-Sclerosis
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 83a
Of autopsy no

Duration

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? (e) Means of injury 0
23. Signature J. W. SEABOLD (M. D. ~~or other~~)
Address J. W. SEABOLD Date signed 7-7

(Licensed Embalmer's Statement on Reverse Side)

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.