

No. 2  
-1/47  
5-17-39

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33029

Registrar's No. 9076

FILED OCT 4 1947 318

Registration District No. ....

Primary Registration District No. ....

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 Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 020

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

(d) Street No. 2717 (rear) Delmar  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mamie Lee Smith

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 28  
year 1947 hour 7:00 minute 10 P. M.

21. I hereby certify that I attended the deceased from May 26, 1947, to Aug. 28, 1947; that I last saw h. er. alive on Aug. 28, 1947; and that death occurred on the date and hour stated above.

5. Color or race Col.

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

6. (b) Name of husband or wife.....

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

7. Birth date of deceased: Unknown  
(Month) (Day) (Year)

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced

Due to.....

Due to.....

Other conditions: None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy: No

PHYSICIAN  
Underline the cause of which death should be charged statistically.

8. AGE: Years 16 Months Days If less than one day  
abt. hr. min.

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

10. Usual occupation: "

11. Industry or business.....

12. Name: John Smith

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

14. Maiden name: Unknown

15. Birthplace: "  
(City, town, or county) (State or foreign country)

16. (a) Informant: Elizabeth Rhodes

(b) Address: 2601 N. Whittier St.

17. (a) Anatomical Board (b) Date thereof: 9-8-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Louis

18. (a) Signature of funeral director: [Signature]

(b) Address: 2400 Rutland

19. (a) SEP 30 1947 (b) [Signature]  
(Date received local registrar's) (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?..... (Specify type of place)

While at work?..... Means of injury.....

23. Signature: [Signature] (M. D. or other)  
Address: 2601 N. Whittier Date signed: 9/30/47

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

MOTHER FATHER

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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 \_\_\_\_\_

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.