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

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 4 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 33034
Registrar's No. 9416

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 25 days (Specify whether years, months or days)
In this community over 8 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 4267 Enright (If rural, give location) 9
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Walter Smith
3. (b) If veteran, name war NO
3. (c) Social Security No. —
4. Sex Male 1
5. Color or race Col
6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
About 65			hr. min.

9. Birthplace unknown (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name unknown 4
13. Birthplace " 1 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name unknown 7
15. Birthplace " (City, town, or county) (State or foreign country)
16. (a) Informant A. L. Beal Undertaker
(b) Address 4203 Delmar
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-47 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine
18. (a) Signature of funeral director A. L. Beal Undertaker
(b) Address 4203 Delmar
19. (a) OCT 4 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 27 year 1947 hour 6 minute 30 M.
21. I hereby certify that I attended the deceased from Sept. 2, 1947 to Sept. 27, 1947; that I last saw him alive on Sept. 27, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Severe Peri-dental Infection	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Chr. Pneumonitis (cause undetermined)	

Major findings:
Of operations
Of autopsy No

PHYSICIAN
Underline the cause of 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 0
23. Signature Burton L. Phillips (M. D. or other)
Address 2601 N Whittier Date signed 9/30/47

Jefferson City Printing Co.
(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 Vora J. Wilson

Licensed Embalmer No. 4435

P. O. Address 2618 Bellingh

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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9116

SUPPLEMENTARY

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:
(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 (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Walter Smith

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m

5. Color or race B

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

6. (b) Name of husband or wife

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

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

8. AGE: Years aft 65 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J. F. Brueck (Registrar's signature)
OCT 10 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 27
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

33034

Jr 2726

nc - 9278