

No. 2  
12-45  
5-17-39  
1 X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36280

State File No. \_\_\_\_\_

FILED NOV 3 1947

318

Primary Registration District No. 1003

Registrar's No. 9692

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:  
1113 Montgomery  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community 46 yrs  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_

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

(d) Street No. 1113 Montgomery  
(If rural, give location)

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

3. (a) PRINT FULL NAME Lena M Smith

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18  
year 1947 hour 9:45 P M minute \_\_\_\_\_ M.

4. Sex F / 5. Color or race W

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

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

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

21: I hereby certify that I attended the deceased from 7-25-47  
19\_\_\_\_ to 10-18 1947  
that I last saw her alive on 10-17- 1947  
and that death occurred on the date and hour stated above.

7. Birth date of deceased Apr 1 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>6</u>	<u>17</u>	hr. _____ min. _____

Immediate cause of death Cardiac  
decompensation

Duration 2 mo

9. Birthplace Perry Co Mo  
(City, town, or county) (State or foreign country)

Due to Arterio Sclerotic  
Heart Disease

Due to Senility

10. Usual occupation Housewife

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business Own Home

12. Name Thomas Dean

Major findings:  
Of operations none

Of autopsy none

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

13. Birthplace Perry Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name O'Meary

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

16. (a) Informant Oscar Black

(b) Address Overland Mo

17. (a) Burial (b) Date thereof 10/21/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Perryville Mo  
Ortmann Funeral Home

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address 9222 Lackland, Overland Mo

19. (a) OCT 20 1947 (b) J. F. Bredsch  
(Date received in Registrar's office) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence none

(c) Where did injury occur? none  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place)

(e) Means of injury none

23. Signature W. E. Staebble (M. D. or other) M.D.  
Address 7124 Natural Bridge Date signed 10-22-47

WRITE PLAINLY—USE 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 W. C. Ostmann

Licensed Embalmer No. 3478

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.**