

FILED DEC 31 1947
318

Registration District No. 318 Primary Registration District No. Registrar's No. 11626

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... **SAINT LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution.....
4500 CLARENCE AVENUE
(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..... **MISSOURI** (b) County.....
(c) City or town..... **SAINT LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **4500 CLARENCE AVENUE**
(If rural, give location)
(e) Citizen of foreign country?..... **NO** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... **SETH P. SMITH, M. D.**
3. (b) If veteran, name war.....
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month..... **DECEMBER** day..... **19th**
year..... **1947** hour..... **4** minute..... **00** P..... M.....

4. Sex..... **MALE** 5. Color or race..... **WHITE**
6. (a) Single, widowed, married, divorced..... **MARRIED**
6. (b) Name of husband or wife..... **MABEL SMITH nee LINDVALL**
6. (c) Age of husband or wife if alive..... **63** years
7. Birth date of deceased..... **SEPTEMBER 23rd, 1882**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from.....
Jan 1, 1947 to..... **Dec 19, 1947**
that I last saw him alive on..... **Dec 10, 1947**
and that death occurred on the date and hour stated above.
Duration

8. AGE: Years Months Days If less than one day
65 **2** **26** hr. min.

Immediate cause of death.....
Coronary heart disease 2 yrs
Due to..... **Coronary sclerosis** 2 yrs +
Due to..... **Cause unknown**

9. Birthplace..... **RACINE, WISCONSIN**
(City, town, or county) (State or foreign country)

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

10. Usual occupation..... **PHYSICIAN**

Major findings:
Of operations.....

11. Industry or business..... **SELF**

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

12. Name..... **JOHN B. SMITH**
13. Birthplace..... **UNKNOWN**
(City, town, or county) (State or foreign country)

14. Maiden name..... **HELEN I. PHELPS**
15. Birthplace..... **WISCONSIN**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **MRS. MABEL SMITH**
(b) Address..... **4500 CLARENCE AVENUE**

17. (a) **BURIAL** (b) Date thereof..... **12/22/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **BELLEFONTAINE CEMETERY**

18. (a) Signature of funeral director..... **CALVIN F. FEUTZ**
(b) Address..... **4828 NATURAL BRIDGE BOULEVARD**

19. (a) **DEC 22 1947** (b) **J. F. Bredeck**
(Date received local registrar) (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?..... (e) Means of injury.....

23. Signature..... **Thomas H. ...** (M. D. or other)
Address..... **1117 N Grand** Date signed..... **12/20/47**

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

see page 1000.
1117 Grand Ave - 2-4-19m

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 Ralph C. Lenders

Licensed Embalmer No. 4275

P. O. Address St. Louis, Mo.

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.