

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

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED MAR 11 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

7057

1706

Registration District No. 318

Primary Registration District No. 1003

Registrar's 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 C Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether  
in this community.....  
years, months or days)

3. (a) PRINT FULL NAME Tim Smith

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Kathe Smith 6. (c) Age of husband or wife if alive..... years

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

8. AGE: abt - 70 Years Months Days If less than one day  
? ? hr. min.

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

10. Usual occupation Laborer

11. Industry or business.....

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Elizabeth Rhodes  
(b) Address 2601 N Whittier

17. (a) Burial (b) Date thereof 2/19/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Dale Cemetery

18. (a) Signature of funeral director Miss Anna Stewart  
(b) Address 215 So. Jefferson Ave

19. (a) Feb 19 1948 (b) J. F. Bradick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County aco  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 206 1/2 S 23rd St  
22 (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16  
year 1948 hour 2 minute 20 p. M.

21. I hereby certify that I attended the deceased from Feb. 14 19 48 to Feb. 16 19 48  
that I last saw him alive on Feb. 16 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE  
Hypertension

Due to.....

Due to.....

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

Due to.....

Major findings:  
Of operations.....

Of autopsy None

Due to.....

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)

(e) Means of injury.....

23. Signature Oliver L Daniels (M. D. or other).....

Address 2601 N Whittier St Date signed 2/19/48

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

MOTHER FATHER

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.....

*Not Embalmed*....., Registered Apprentice No.....,  
working under my personal supervision.

Signed *Alvin J. Homeyer* *Jessie M. [unclear]*

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.