

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25058
Registrar's No. 1789

FILED AUG 13 1948
Registration District No. 7

Primary Registration District No. 6 876

1. PLACE OF DEATH:

(a) County ST. Louis
(b) City or town FLORISSANT
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
305 ST. LOUIS STREET /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 50 yrs years, months or days

3. (a) PRINT FULL NAME

Mary Emelie Smith

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex FEMALE

5. Color or race WHITE

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

(b) Name of husband or wife CHARLES M. SMITH

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

7. Birth date of deceased SEPT 22 1862
(Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 1 If less than one day hr. _____ min. _____

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER { 12. Name JOHN KEHRMAN 4

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

14. Maiden name HENRIETTA ZOECKLER

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

16. (a) Informant ELINOR BLANDFORD

(b) Address 305 ST. LOUIS ST - FLORISSANT, MO.

17. (a) BURIAL (b) Date thereof 7-24-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST PETERS CEM.

18. (a) Signature of funeral director A.W. McLAUGHLIN

(b) Address 2301 WABAYETTE

19. (a) 7-24-48 (b) Gene C. Glayton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. Louis 96
(c) City or town FLORISSANT 10
(If outside city or town limits, write "RURAL")
(d) Street No. 305 ST. LOUIS STREET U
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) U
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22 year 1948 hour 10:20 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 1947 to July 22 1948
that I last saw her alive on July 20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Stroke
stroke terminal Duration 2 day

Due to hypertensive cardiac vascular renal disease 75

Due to _____
Other conditions fracture 1960
(Include pregnancy within 5 months of death) pelvis

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) accident 96

(b) Date of occurrence July 9, 1948

(c) Where did injury occur? Denver, CO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home NO (Specify type of place) None
While at work? NO (e) Means of injury fall

23. Signature Gene C. Glayton (M. D. or other) MD
Address 9610 S. Grand Date signed 7/24/48

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

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.....

O. W. Cooper

Licensed Embalmer No. *3839*

P. O. Address *2301 Lakewood*

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.