No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31579

FILED OCT 4 1948

Registration District No. 1949

Primary Registration District No. 3063

Registrar's No. 2128 2129

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 hrs (Specify whether
In this community 1yr. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis 96
(c) City or town Wellston 0
(If outside city or town limits, write "RURAL")
(d) Street No. 6441 Wellsmar 0
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Callie Smoot
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced Sept
6. (b) Name of husband or wife Charlie Smoot
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. (Month) 21 (Day) 1891 (Year)

8. AGE: Years 57 Months Days 18 If less than one day hr. min.

9. Birthplace Dixon (City, town, or county) Tenn. 1 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name James Brazzell
13. Birthplace Dixon (City, town, or county) Tenn 1 (State or foreign country)
MOTHER
14. Maiden name Sarah Lane
15. Birthplace Dixon (City, town, or county) Tenn. 1 (State or foreign country)
16. (a) Informant County Hospital Records
(b) Address Clayton, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-48 (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews
18. (a) Signature of funeral director Calvin-Feutz
(b) Address 4828 Natural Bridge
19. (a) 9-9-48 (Date received local registrar) (b) Carl A. J. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9
year 1948 hour 5 minute 10 A.M.
21. I hereby certify that I attended the deceased from Sept. 8, 1948, to Sept. 9, 1948; that I last saw her alive on Sept. 9, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Peritonitis, origin and cause unknown.	36 hrs
Due to	
Due to 122 hrs	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Peritonitis and partial volvulus of ileum
Of autopsy Peritonitis and congestion of lungs.

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 0

23. Signature Robert H. Kiell (M. D. ~~or other~~)
Address 601 Brentwood Blvd Date signed 9-9-48

(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 John A. Mlinar

Licensed Embalmer No. 4486

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.