

FILED NOV 12 1948  
Registration District No. **1003**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town City St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution City Military Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8-3-42-10-9-48  
(Specify whether In this community..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 17  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL") 0  
(d) Street City Infirmary  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 10- day 9-  
year 1948 hour 12 minute 45 a.m.

4. Sex m 5. Color col 6. (a) Single widowed married, divorced separated  
(b) Name of husband or wife Mollie 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased Aug 20 1885  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1942, 19..... to 10- 9- 1948  
that I last saw him alive on 10-9- 1948  
and that death occurred on the date and hour stated above.  
Duration

8. AGE: Years 63 Months 1 Days 19 If less than one day hr. min.

Immediate cause of death Heart Failure  
terminal Bronchopneumonia  
Due to generalized arterio-sclerosis  
& cerebral and cardiac congestion  
Due to encephalomalacia  
Other conditions Decubiti  
(Include pregnancy within 3 months of death)

9. Birthplace..... (City, town, or county) (State or foreign country)  
10. Usual occupation.....  
11. Industry or business.....  
12. Name Joe Smith  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name Mary Allen  
15. Birthplace..... (City, town, or county) (State or foreign country)

Major findings: Of operations 107  
Of autopsy none  
PHYSICIAN  
Underline the cause of which death should be charged statistically.

16. (a) Informant Infirmary Records  
(b) Anatomical Board  
17. (a) Anatomical Board (b) Date thereof OCT 31 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Anatomical Board  
18. (a) Signature of funeral director Rowland Mortuary Service  
4104 Manchester Ave.  
(b) Address.....  
19. (a) OCT 31 1948 (b) J.B. Slaughter  
(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 0  
23. Signature Clifton Kray M.D. (M. D. or other)  
Address 5600 Arsenal St Date signed OCT 10 1948

St Louis

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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 \_\_\_\_\_

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.