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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED NOV 12 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **34721**  
Registrar's No. **9421**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis  
(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 G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 16 days (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

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

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife Not known 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 30 (Month) (Day) (Year)

8. AGE: Years 63 Months - Days - If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

12. Name Charlie Smith  
13. Birthplace Not known (City, town, or county) (State or foreign country) 7  
14. Maiden name Not known  
15. Birthplace " " (City, town, or county) (State or foreign country) 9

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

17. (a) Anatomical Board (b) Date thereof OCT 31 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: Burial Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service  
(b) Address 4104 Manchester Ave.

19. (a) OCT 31 1948 (Date received local registrar) J. B. Casater (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 2603 Pine St (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7  
year 1948 hour 4 minute 20 a. M.

21. I hereby certify that I attended the deceased from Sept. 21 19 48 to Oct. 7 19 48  
that I last saw h. im alive on Oct. 7 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardiovascular Disease and Probable Pulmonary Embolism Duration Undet.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions None (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy None **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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury ?  
23. Signature J. B. Casater (M. D. or other) \_\_\_\_\_  
Address 2601 N Whittier Date signed 10/11/48

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

MOTHER FATHER

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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.**