

No. 300  
10-47  
17-39  
1-2906

FILED OCT 23 1948  
Registration District No. **377**

Primary Registration District No. **2669**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether in this community years, months or days)

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. 4462a McPherson  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME Donald William Smith

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Oct. day 9 year 1948 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from Sept 3/48 to Oct 9/48, 1948, that I last saw him alive on Oct 9/48, 1948; and that death occurred on the date and hour stated above.

4. Sex Male

5. Color of race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 29 1947  
(Month) (Day) (Year)

Immediate cause of death Pneumonia

Duration 3 weeks

Due to \_\_\_\_\_

Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day

1	4	10	hr. _____ min. _____
---	---	----	----------------------

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

10. Usual occupation Child

Other conditions Cerebral Spastic Paralysis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name James William Smith

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

14. Maiden name Lucille McGreager

15. Birthplace Glenn Allen Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant E.P. McGreager

(b) Address 4466a McPherson

17. (a) Burial (b) Date thereof 10-12-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Glenn Allen, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) OCT 11 1948 (b) Bessie Sharp  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

Means of injury fall

23. Signature Robert J. Pele M.D. or other \_\_\_\_\_

Address St. Mary's Hospital Date signed 10/10/48

**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 Elton R. Penelias

Licensed Embalmer No. 42831

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.**