

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38660**
Registrar's No. **9696**

FILED NOV 24 1948

Registration District No. **318** Primary Registration District No. **1005**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution: **Homer G. Phillips Hospital**
(d) Length of stay: **less than 24 Hours**
In this community **6 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(d) Street No. **4575 Enright Ave.**
(e) Citizen of foreign country? **no**

3: (a) PRINT FULL NAME **Roy Smith**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **492-05-4656**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **November** day **4**
year **1948** hour **11:00** minute **A.** M.

4. Sex **Male** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Alice Smith** 6. (c) Age of husband or wife if alive **42** years
7. Birth date of deceased **June 16 1907**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years **41** Months **4** Days **18** If less than one day _____ hr. _____ min.

Immediate cause of death **Pulmonary Tuberculosis**
Due to _____
Due to _____

9. Birthplace **Arkansas**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) **1/2**

10. Usual occupation **Laborer**

Major findings: Of operations _____
Of autopsy _____

11. Industry or business **Wagner Electric Corp.**

12. Name **John Smith,**
13. Birthplace **unknown** **Arkansas**
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**
15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Alice Smith**
(b) Address **4575 Enright Ave.**

17. (a) **Burial** (b) Date thereof **11-9-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cemetery**
Ellis Funeral Home

18. (a) Signature of funeral director _____
(b) Address **2820 Stoddard St.**

19. (a) **NOV 8 1948** (b) **J. B. Padater**
(Date received local registrar) (Registrar's signature)

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? _____
(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 **fall**
23. Signature **Philip E. ...** (Date or other) _____
Address _____ Date signed **11/9/48**

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

MOTHER, FATHER

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 Luther E. Culshaw

Licensed Embalmer No. 4198

P. O. Address Shawnee 13, 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.