

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEC 13 1937

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

39901  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**  
 (b) Township..... Primary Registration District No. **1003**  
 (c) City **St. Louis,** (d) Street No. **City Hospital No. 1** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
**C. 11818**

Registered No. **10888**

2. PRINT FULL NAME

**Clifford Smith**  
 (a) Residence, No. **4001 Delmar** St. **19**  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept 29, 1905**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**32 1 25**

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. **baker helper**  
 10. Date deceased last worked at this occupation (month and year) **About 1932**  
 11. Total time (years) spent in this occupation **3 Yrs.**

12. BIRTHPLACE (CITY OR TOWN) **Carbondale,**  
 (STATE OR COUNTRY) **Illinois**

FATHER  
 13. NAME **Louis Smith**

14. BIRTHPLACE (CITY OR TOWN) **Ohio**  
 (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME **Mattie Dixon**

16. BIRTHPLACE (CITY OR TOWN) **Illinois**  
 (STATE OR COUNTRY)

17. INFORMANT **Hosp. Info M. Kent**  
 (ADDRESS) **City Hospital #1**

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE **Carbondale, Ill** DATE **November 26, 37**

19. FUNERAL DIRECTOR **Albert H. Hoppe Inc.,**  
 (ADDRESS) **429 N. Euclid Avenue**

20. EMER. **J. Bredel** 19  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11/24/37**, 19

22. I HEREBY CERTIFY, That I attended deceased from **11/11/37**, 19, to **11/24/37**, 19.

I last saw him live on **11/24/37**, 19. Death is said to have occurred on the date stated above, at **2:30 a.**

The principal cause of death and related causes of importance were as follows:

*Pulmonary tuberculosis, chronic*  
 Date of onset  
 Other contributory causes of importance:  
*J. D.*

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify *Chas. J. Jamison*, M. D.  
 (Address) **City Hospital No. 1**

STATEMENT BY LICENSED EMBALMER

I, Benj. C. Duncan, Licensed Embalmer No. 2272

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....  
working under my personal supervision.

Signed Benj. C. Duncan  
Licensed Embalmer No. 2272

**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.)**