

DESD, APR 12 1939

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

8647  
Do not use this space.  
2412

1. PLACE OF DEATH

(a) County.....  
(b) Township.....  
(c) City St. Louis..... (d) Street No. Missouri Pacific Hospital..... 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.

2. PRINT FULL NAME Alonzo Luther Smith

(a) Residence, No. 1411 Kansas Ave. St. WA Atchison, Kans.  
(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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 28, 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
67 1 15

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Michigan

FATHER 13. NAME Louis Smith

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Michigan

MOTHER 15. MAIDEN NAME Louisa Shupert

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT Mrs. C. J. Boatwright  
(ADDRESS) 2008 St. Joseph Ave., St. Joe, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Atchison, Kans DATE 3/13/39

19. FUNERAL DIRECTOR (NAME) Robert J. Ambruster  
(ADDRESS) Clayton Rd. at Concordia Lane

20. FILED MAR 14 1939 J. D. Budlich  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 13, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 8, 1939, to March 13, 1939  
I last saw him alive on March 13, 1939. Death is said to have occurred on the date stated above, at 5:30 P.M.  
The principal cause of death and related causes of importance were as follows:

Hemiplegia (Rt)  
Chronic Myocarditis  
Old hemiplegia (left)  
caused by cerebral hemorrhage  
Date of onset 3/7/39  
Other contributory causes of importance:  
34000

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? No

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? no  
If so, specify.....

(Signed) R. O. Dwyer M. D.  
(Address) Missouri Pacific Hospital  
St. Louis, Mo.

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.

**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

*Richard A. Backlund*

Licensed Embalmer No. 2502

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, above space should be left blank.**