

Registration District No. **791** Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH: **1003**
(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: St. Luke's Hospital, 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community 7 days years, months or days)

3. (a) PRINT FULL NAME George M. Smith, 530
3. (b) If veteran, name war unknown 3. (c) Social Security No. unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife ? Smith 6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased November 24, 1875. (Month) (Day) (Year)

8. AGE: Years 63 Months 7 Days 11 If less than one day hr. min.

9. Birthplace Macon, Illinois. (City, town, or county) (State or foreign country)

10. Usual occupation Auto Salesman.

11. Industry or business
MOTHER FATHER { 12. Name Saxton Smith,
13. Birthplace New Jersey. (City, town, or county) (State or foreign country)
14. Maiden name Catherine Murdock.
15. Birthplace unknown. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature H. Jordan
(b) Address 7140 Westmont Ave
17. (a) removal (b) Date thereof July 6, 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Decatur, Illinois.

18. (a) Signature of funeral director Wagoner Und. Co.
(b) Address 3621 Olive St.
19. (a) JUL 6, 1939 (Date received local registrar) (b) J. B. Budeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois, (b) County _____
(c) City or town Springfield, (If outside city or town limits, write "RURAL") **NR**
(d) Street No. 812 N. 6th Street. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5 year 1939 hour 1:00 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from June 28, 1939 to July 5, 1939 that I last saw him alive on July 25, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death: Paralysis agitans
Due to Pneumonia
Due to terminal
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Crematory, for Parkinson's Disease 6-303
Of operations _____
Of autopsy _____

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 1
23. Signature A. M. Klumpp (M. D. or other)
Address Beaumont Bldg. Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 Elmer Crocker
Licensed Embalmer No. 3351
P. O. Address 3621 Olive St.

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.