

REC'D AUG 11 1939
791
Registration District No. **1003**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: City Hospital #1
(d) Length of stay: In hospital or institution 1 Day
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(d) Street No 1520 S. 7th St
(e) If foreign born, how long in U. S. A. _____ years.

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Louis Smith 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased November 6 1896
(Month) (Day) (Year)

8. AGE: Years 42 ~~X~~ Months 8 Days 4 If less than one day, hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business At Home

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. (a) Informant's own signature Louis Smith
(b) Address 1520 S. 7th St

17. (a) Cremation (b) Date thereof July 13 1939
(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Petz Brothers
(b) Address 3029 Lafayette Ave

19. (a) JUL 12 1939 (b) J.P. Brader
(Date received local registrar) (In presence of)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th
year 1939 hour 10:00 P.M.
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.

Immediate cause of death Aortic Stenosis with Cardiac Hypertrophy; Contrib: Hydrops Pericardii
Due to Hypertrophic Portal Cirrhosis;
Chronic

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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? _____ (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 _____
23. Signature Deputy Registrar (U.S. or other) _____
Address _____ Date signed 7/10

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

Frank J. Jones

Licensed Embalmer No.

2245

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; above space should be left blank.