

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.

AUG 11 1939

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS **791**
 CERTIFICATE OF DEATH **1008**

 24005
 Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis ³ Registration District No. _____
 (b) Township _____ Primary Registration District No. _____
 (c) City _____ (d) Street No. Mississippi River Ferry Branch St. ⁶²⁷⁸
 (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

(a) Residence, No. 530 John W. Smith 1114 S. 11th St. St. **22** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (write name) <u>Lynne Smith</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>JAN. 13. 1877</u>		
7. AGE <u>62</u> YEARS	<u>6</u> MONTHS	<u>2</u> DAYS If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		
13. NAME <u>George Smith</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		
15. MAIDEN NAME <u>Mary Gibbons</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		
17. INFORMANT (ADDRESS) <u>Jack Sacovian</u> <u>4654 1/2 E. Ave</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Calvary</u> DATE <u>7-17-39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Succession and Co.</u> <u>2849 N. Cicero</u>		
20. FILED <u>JUL 16 1939</u> <u>J. F. B. [Signature]</u>		

No MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-15-1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ p. m.
 The principal cause of death and related causes of importance were as follows:
Asphyxiation due to (Date of onset)
drowning when he jumped
from bridge at the foot
of Grand Street into the
Mississippi River on
July 14-1939 at about 4:23 AM
 Other contributory causes of importance:
None
 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 7/14/39
 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 _____
 (Signed) Julius [Signature] 'M. D.
 (Address) 1716 [Signature] 3f

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 Albert W. Mayfield

Licensed Embalmer No. 5677

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.