

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.

JAN 12 1934

Registration District No. **291** Primary Registration District No. _____

1. PLACE OF DEATH: **1003**
(a) County **ST. LOUIS** **1**
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **HOMER G. PHILLIPS HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **APT 14 HRS.**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **EVELYN SMITH 5 29**
3. (b) If veteran, name war
3. (c) Social Security No. **498-10-9067**

4. Sex **FEMALE** 5. Color or race **COL.** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **JOE SMITH** 6. (c) Age of husband or wife if alive **ART. 46** years
7. Birth date of deceased **JUNE 14 1895**
(Month) (Day) (Year)

8. AGE: Years **44** Months **6** Days **2** If less than one day hr. min.

9. Birthplace **INDINOLA MISS.**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **1**

MOTHER FATHER
12. Name **AUSTIN BAEFORD 9**
13. Birthplace **UNKNOWN UNKNOWN**
(City, town, or county) (State or foreign country)
14. Maiden name **UNKNOWN**
15. Birthplace **UNKNOWN UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Joseph B. Stevenson**
(b) Address **1610^a Delmar Blvd**

17. (a) **BURIAL** (b) Date thereof **DEC. 23-39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **FATHER DIXSONS**

18. (a) Signature of funeral director **LOVE UND. CO. INC.**
(b) Address **3103 WASHINGTON BLYD.**

19. (a) **DEC 20 1939** (b) _____
(Date certified legal registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED: **1**
(a) State **MISSOURI** (b) County **ST. LOUIS**
(c) City or town **ST. LOUIS 215**
(If outside city or town limits, write "RURAL")
(d) Street No. **1610^a DELMAR BLYD.**
(If rural, give location)
NO PHYSICIAN IN ATTENDANCE
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **14**
year **1934** hour **5:30** minute _____ 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: **Chronic Myocarditis;**
Chronic parenchymetous nephritis;

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

Duration _____
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 special place) (e) Means of injury **24**

23. Signature **Joseph B. Stevenson** M. D. or other _____
Address **Deputy Coroner**

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 Arthur L. Hilliard

Licensed Embalmer No. 3389

P. O. Address. 3028 Dickson 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.