

JAN 12 1940

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County 1  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Firmin Desloge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Carolyn 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 John Henry 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased April 20 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>8</u>	<u>3</u>	_____ hr. _____ min.

9. Birthplace Cape Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Fred Godfred

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Arnold Smith

(b) Address Festus, Mo.

17. (a) Removal (b) Date thereof 12/25/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) DEC 26 1939 (b) \_\_\_\_\_  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson  
(c) City or town Festus N.R.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 23rd  
year 1939 hour six minute 10 P. M.

21. I hereby certify that I attended the deceased from August 8th, 1939, to December 23, 1939;  
that I last saw her alive on December 23, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized toxemia

Due to Gangrene of lower extremities 0 mo.

Due to Diabetes mellitus 9 yrs

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Gangrene of right foot

Of autopsy None allowed

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?  
\_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury 1

23. Signature Edward Keen (M. D. or other) M. D.  
Address 1325 So. Grand Blvd. Date signed 12-23-39

Duration  
1 mo.  
0 mo.  
9 yrs  
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.

10985  
9860T

**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 *Robert W. Nappa*

Licensed Embalmer No. *1861*

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.**