

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St Louis
(c) Name of hospital or institution: Homer G Phillips Hospital
(d) Length of stay: 2 days
In this community Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St Louis
(d) Street No. 3827 a Windsor
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Josie Smith
3. (b) If veteran, name war
3. (c) Social Security No. 531

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 24
year 1939 hour 1:00 minute 45 AM.

4. Sex FEMALE 5. Color or race Col.
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife CLARENCE SMITH
6. (c) Age of husband or wife 45 years
7. Birth date of deceased 2 22 1897

21. I hereby certify that I attended the deceased from December 22 1939, to December 24 1939;
that I last saw her alive on December 24 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Subacute Nephritis caused by chronic nephritis from pyeloperphal.
Duration 7-10 days

8. AGE: Years 42 Months 10 Days 2
If less than one day hr. min.

Other conditions 191
Major findings: Of operations _____
Of autopsy _____

9. Birthplace ST. LOUIS MO.

10. Usual occupation HOUSEWIFE
11. Industry or business _____
12. Name CHARLES SODRIDGE
13. Birthplace UNKNOWN UNKNOWN
14. Maiden name ALICE JOHNSON
15. Birthplace ST. LOUIS MO.

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

16. (a) Informant's own signature Clarence Smith
(b) Address 3827 a Windsor Pl
17. (a) BURIAL (b) Date thereof 12-28-39
(c) Place: burial or cremation WASHINGTON PARK

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director LOVE UND. CO. INC.
(b) Address 3103 WASHINGTON BLVD.
19. (a) DEC 23 1939 (b) _____

While at work? _____
28. Signature J. J. Miller (M. D. or other) _____
Address 501 N. W. 11th Date signed 12/26/39

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 Arthur R. Hilliard

Licensed Embalmer No. 3389

P. O. Address 3028 Dickson S.

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.