

FEB 17 1940

791

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 91

1. PLACE OF DEATH: 1008
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
De Paul 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 530 Aubert Smith
8. (b) If veteran, name war _____ Nil
8. (c) Social Security No. _____ Nil

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Jessie Smith
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 18, 1878.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 9 13 _____ hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business Insurance Company

12. Name John C. Smith

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

14. Maiden name AMANDA Young

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

16. (a) Informant's own signature Frank C. Smith

(b) Address 204 S. Maple, Pak Park Ill.
Removal

17. (a) _____ (b) Date thereof 1/2/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) 1009 5 1940 (b) _____
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED: D
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4257 W Washington Blvd.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31
year 1939 hour 5 minute _____ p. M.

21. I hereby certify that I attended the deceased from Nov 1
_____, 1939, to Dec 31, 1939;
that I last saw him alive on Dec 30, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Acute lymphatic leukemia 6 wks?

Due to As not known
Due to _____

Other conditions Nothing abnormal
(Include pregnancy within 3 months of death)

Major findings: None
Of operations No operation

Of autopsy Report not completed

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)
(a) Means of injury _____

28. Signatur R. Baumert (M. D. or other) _____
Address 1117 N Grand Date signed 1/2/40

Duration

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. PREVENTING BLACK INK—MAKE A PERMANENT RECORD

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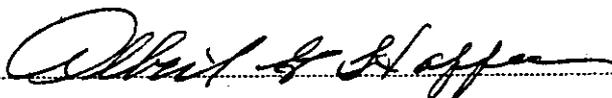
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STATEMENT BY LICENSED EMBALMER

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..... .....

Licensed Embalmer No. 2971.....

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.