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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4216

Registration District No. 791 FILED MAR 12 1940 Primary Registration District No. 1003 Registrar's No. 1046

1. PLACE OF DEATH:

(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: Masonic Home of Missouri
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 years (Specify whether years, months or days)

In this community Same

2. USUAL RESIDENCE OF DECEASED: 12

(a) State ~~Missouri~~ (b) County

(c) City or town ~~Cameron~~ NR
(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.

3. (a) PRINT FULL NAME Mrs. Mattie Smith

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 Widow

6. (b) Name of husband or wife J. K. P. Smith

6. (c) Age of husband or wife if alive years

7. Birth date of deceased September 4, 1852 (Month) (Day) (Year)

8. AGE: Years 87 Months 4 Days 27 If less than one day hr. min.

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

10. Usual occupation 9

11. Industry or business Lived in Masonic Home

FATHER 12. Name Unknown 9

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

MOTHER 14. Maiden name Mary Ethington

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

16. (a) Informant's own signature Clara Rothe

(b) Address 5351 Delmar Blvd. St. Louis, Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Cameron. Mo

18. (a) Signature of funeral director Poland Funeral Home

(b) Address Cameron, Mo

19. (a) FEB 1 1940 (Date received local registrar) (b) J. T. Blackerby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 1 year 1940 hour 3. 15 minute A. M.

21. I hereby certify that I attended the deceased from January 30 1939, to February 1, 1940, that I last saw her alive on January 31 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Valvular Heart Disease	1 yr.
Due to: Chr. Interstitial Nephritis	6mths.
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Dolores Lamuraz (M. D. or Coroner)

Address 508 N. Grand Blvd. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Howard F. Rowland

Licensed Embalmer No. 3114

P. O. Address St Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.