DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20559

Registration District No. 79 Primary Registration District No. 1003 Registrar's No. 5507

JUL 17 1940

1. PLACE OF DEATH:

(a) County

(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Saint Louis Maternity Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community Non-Resident
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Saint Clair 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.

3. (a) PRINT FULL NAME Smith Infant 530

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 13 (Day) 1940 (Year)

8. AGE: Years | Months | Days | If less than one day 7 & hr. 50 min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Charles Thomas Smith
13. Birthplace Saint Louis (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Alberta May Williams
15. Birthplace St. Francis Co. (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature St. L. Maternity Hosp
(b) Address 630 S. Kingshighway

17. (a) (Burial, cremation, or removal) (b) Date thereof JUN 27 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Washington University Dept. of Pathology

18. (a) Signature of funeral director
(b) Address Wash. Univ.

19. (a) JUN 27 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th year 1940 hour 5 minute 40 A.M.

21. I hereby certify that I attended the deceased from June 13th 9:50 P.M., 1940, to 6-14- 5:40A.M. 1940 that I last saw him alive on June 14, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity - 23 wks gestation

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature J. F. Nolan (M. D. or other)

Address 630 So. Kingshighway Date signed 6/15/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

REV. 3-17-39 1 X19511

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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.....

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.