

Registration District No. 784

Primary Registration District No. 104

Registrar's No. 1450

1. PLACE OF DEATH:

(a) County. St. Louis
(b) City or town. Ferguson, Mo.
(c) Name of hospital or institution:
25 Lake Ave.
(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. (b) PRINT FULL NAME Frank P. Smith, 530

3. (b) If veteran, name war. no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Nellie Smith 6. (c) Age of husband or wife if alive. 62 years

7. Birth date of deceased. July 16, 1870.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 0 15 hr. min.

9. Birthplace Buffalo, New York
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business

MOTHER FATHER { 12. Name ? Smith
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Don't know
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Smith

(b) Address Ferguson, Mo.

17. (a) Burial (b) Date thereof Aug. 3/40.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ferdinand Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodgkiss Ave.

19. (a) AUG - 2 1940 (b) R. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo. (b) County. St. Louis
(c) City or town Ferguson, Mo.
(If outside city or town limits, write "RURAL.")
(d) Street No. 25 Lake Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1940 hour 12.45 minute P.M.

21. I hereby certify that I attended the deceased from June 1st 1939 to July 31, 1940
that I last saw him alive on July 30, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death. Chronic Interstitial nephritis

Due to _____

Due to _____

Other conditions. 131
(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? _____

207
(While at work? (Specify type of place) (e) Means of injury _____)

23. Signature D. A. Thomson (M. D. or other) 1

Address 312 1/2 Grand Date signed 8/1

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

6
3
1

S

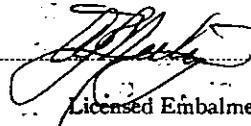
Dr. Thomson, D.A.
3121 N. Grand Ave.,
10-12 2-4 6-8 P.M.
Fr. 1244

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. 3225.

P. O. Address 1125 Hodiament Ave.,

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.