

NOV 16 1940 791
Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 8281

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DEACONESS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME HARRY SMITH
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
7. Birth date of deceased MARCH 21, 1868
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation STORE KEEPER

11. Industry or business BOOK STORE

MOTHER FATHER
12. Name UNKNOWN SMITH
13. Birthplace DON'T KNOW
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN KIENSTER
15. Birthplace DON'T KNOW
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature MRS. ROBERT DAVIS
(b) Address 2120 PORTIS AVE.

17. (a) BURIAL (b) Date thereof OCT. 5, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation NEW ST. MARCUS CH

18. (a) Signature of funeral director WEICK BROS UND Co
(b) Address 2201 So. Grand

19. (a) OCT 4 1940 (b) _____
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 18
(If outside city or town limits, write "RURAL")
(d) Street No. 4429 MANCHESTER AVE.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 3 year 40 hour 2:00 minute P M.
21. I hereby certify that I attended the deceased from Oct. 1, 1940 to Oct. 3, 1940
that I last saw him alive on Oct. 3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy
Due to Chronic nephritis & nitrogenous Retention
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. F. [Signature] (M. D. or other) M.D.
Address 4501 Manchester Date signed 10-4-40

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 *Henry A Stewart*

Licensed Embalmer No. *3722*

P. O. Address *4210 Washington*

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.