

Register's District No. 791

Primary Registration District No. 1003

Registrar's No. 8889

REC'D NOV 16 1940

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.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1623 Delmar Blvd.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community about 2 1/2 years
years, months or days)

8. (a) PRINT FULL NAME John Smith
 3. (b) If veteran, name war None 8. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Willie R. Smith 6. (c) Age of husband or wife if alive 50 years
 7. Birth date of deceased July 30th. 1878
(Month) (Day) (Year)

8. AGE: Years 62 Months 2 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation Porter

11. Industry or business Federal Reserve Bank

12. Name Unavailable

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Willie R. Smith

(b) Address 4237w N. Market St.

17. (a) Burial (b) Date thereof 10-1-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Chas. J. Galt

(b) Address 4107 Finney Ave.

19. (a) OCT 29 1940 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 4237w N. Market St.
(If rural, give location)
 (e) ~~At foreign birth, how long in U. S. A. _____ years~~

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26th.
 year 1940 hour 2:45 minute 0 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Coronary Thrombosis (Sclerotic)

Due to PH

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) (Cause of injury)

28. Signature [Signature] (M. D. or other) _____

Address [Address] Date signed 10/29/40

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.....

A. T. H. [Signature], Registered Apprentice No. 265
working under my personal supervision.

Signed: *[Signature]*
Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

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

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