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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. **37239**
Registrar's No. **8936**

791

1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **8936**

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:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 mins.
In this community 50 Mins (Specify whether years, months or days)

3. (a) PRINT FULL NAME Baby Smith

3. (b) If veteran, name war Newborn 3. (c) Social Security No. Unknown

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

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

7. Birth date of deceased October 10, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 50 min.

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

10. Usual occupation Nil.

11. Industry or business Nil.

12. Name Howard Smith

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

14. Maiden name Mabel Cox

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

16. (a) Informant Ron Morrison
(b) Address City Hospital #1

17. (a) X Cremation (b) Date thereof 10 31 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital, No. 1

19. (a) OCT 30 1940 (b) J. Bradeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3035 Eads
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 10,
year 1940 hour 6:25 minute P. M.

21. I hereby certify that I attended the deceased from October 10, 1940 to October 10, 1940,
that I last saw him alive on October 10, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Prematurity

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury 1

23. Signature W. D. Hawker (M. D. or other) 10/10/40

Address 1515 Lafayette Ave. Date signed _____

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

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.