

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36442

State File No. _____

NOV 25 1940
Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1933

1. PLACE OF DEATH:

(a) County Saint Louis
(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6227 Wells Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life
years, months or days

3. (a) PRINT FULL NAME Laura Smith

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased unavailable about 1883
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	About 57			hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Brooks

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

14. Maiden name Rachel - Unavailable

15. Birthplace Saint Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Matilda Rice

(b) Address 6211a Wells Avenue

17. (a) Burial (b) Date thereof 10-14-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

19. (a) OCT 14 1940 (b) DR. Memphis Dept
(Date received final report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saint Louis

(c) City or town Wellston
(If outside city or town limits, write "RURAL")

(d) Street No. 6227 Wells Avenue
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 10,
year 1940 hour 7 minute 40 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to October, 1940
that I last saw her alive on October, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Uterine Carcinoma and Fibroid

Due to _____

Due to _____

Other conditions Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 S. E. Mason (M. D. or other) _____
Address 809 North Jefferson Date signed 10/12/40

Duration

2 years

PHYSICIAN

Underline the cause to which death should be charged statistically

WHILE 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.

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. J. [unclear]
.....
working under my personal supervision.

Registered Apprentice No. *265*

Signed *Amelia Hussey*

Licensed Embalmer No. *3528*

P. O. Address *4107 Finney Avenue*

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.