

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH:  
(a) County Saint Louis  
(b) City or town Jefferson Barracks,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Veterans Administration Facility 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Adm: 8-1-40  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Thomas W. SMOCK  
3. (b) If veteran, name war Spanish Amer. 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 5, 1872  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>2</u>	<u>27</u>	hr. min.

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

10. Usual occupation Electrical Contractor

11. Industry or business \_\_\_\_\_

12. Name Not known

13. Birthplace Not known  
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known  
(City, town, or county) (State or foreign country)

16. (a) Informant Clinical Clerk, Schelling

(b) Address VAF., Jefferson Barracks, Mo.

17. (a) BURIAL (b) Date thereof 10-5-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NATIONAL CEMETERY

18. (a) Signature of funeral director [Signature]

(b) Address 7814 S. Bonall

19. (a) OCT 4 1940 (b) [Signature]  
(Disseminated local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town Eldon  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2  
year 1940 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from August 1, 1940, to October 2, 1940  
that I last saw him alive on October 2, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma of left femur and ilium, with spontaneous fracture Duration Unknown

Due to N.M.D.

Due to Lfb

Other conditions Arteriosclerotic & Hypertensive heart disease Unknown

(Include pregnancy within 3 months of death)

Major findings: No operation

Of operations \_\_\_\_\_

Of autopsy None

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? [Signature] (Specify type of place) (Type of injury)

23. Signature C.W. HUGHES, M.D., Chief Med. Off.  
(M. D. or other) 10-2-40  
Address VAF., Jefferson Bks., Mo. Date signed

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

MOTHER FATHER

JUN 27 1958

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

*James E. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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, fact should be so stated above.