

No. 2
4-13-40
-17-39
X23185

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILLED OCT 18 1941

STANDARD CERTIFICATE OF DEATH

State File No. 30395
Registrar's No. 7734

Registration District No. 791

Primary Registration District No. 1003

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: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether _____)
In this community 25 years
(years, months or days)

3. (a) PRINT FULL NAME Robert Smith

3. (b) If veteran, name war _____ 3. (c) Social Security No. 492-258993

4. Sex Male 5. Color of race Pol. 6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Carrie Smith 6. (c) Age of husband or wife if alive 39 years
7. Birth date of deceased Sept 25 1901
(Month) (Day) (Year)

8. AGE: Years 39 Months 11 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation Labor

11. Industry or business _____

12. Name Charlie Smith

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

14. Maiden name James

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

16. (a) Informant Carrie Smith

(b) Address 316 S. Montrose

17. (a) Burial (b) Date thereof 9-26-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director T. A. Green

(b) Address 2915 Franklin

19. (a) SEP 25 1941 (b) J. J. Budeck
(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. 316 S Montrose
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1941 hour 10:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from Sept 16 1941 to Sept 20 1941,
that I last saw him in alive on Sept 20 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Glomerular Nephritis Duration Unknown

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (a) Means of injury _____

23. Signature J. W. Johnson (M. D. or other) _____

Address 2601 N Whittier Date signed 9-22-41

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

10
17
9

100
17
9

0

Duration

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

9-22-41

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

J. A. Gibson

Licensed Embalmer No. *2963*

P. O. Address. *2915 Franklin*

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.