

FILED JAN 13 1943

318

Primary Registration District No. 1003

Registrar's No. 10925

1. 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: Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days  
(Specify whether years, months or days)

In this community 16 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")

(d) Street No. 2309a Chouteau  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME William Smith

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased March 12, 1887  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 28,  
year 1942 hour 10 minute 25 P. M.

21. I hereby certify that I attended the deceased from November 13, 1942, to November 28, 1942; that I last saw him alive on November 28, 1942 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>8</u>	<u>16</u>	hr. _____ min. _____

Immediate cause of death Hypertensive Heart Disease Duration Indef.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Senility with Psychosis Indef.  
(Include pregnancy within 3 months of death)

9. Birthplace S. C.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Nil

12. Name Ed Smith

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

14. Maiden name Ellen Smith

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

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Shirley M. Smith  
(b) Address 2601 N. Whittier St.

17. (a) Funeral Home (b) Date thereof 12-4-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. Kuebler  
(b) Address 5500 Rutledge St

19. (a) DEC 29 1942 (b) J. F. Bredbeck  
(Date received local registrar) (Registrar's signature)

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 A. K. Fleet (M. D. or other) \_\_\_\_\_  
Address 2601 Whittier Date signed 1/30/42

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

MOTHER FATHER

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**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 with the above constitutes grounds for revocation of license.)**

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