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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 1 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1066

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 661

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: Park Lane Memorial Hospital, (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months. (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17
(c) City or town St. Louis, 924 (If outside city or town limits, write "RURAL")
(d) Street No. 2909 Nebraska Av. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mildred B. Smith,

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F

5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Arthur Roy Smith

6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased Dec. (Month) 13 (Day) 1900 (Year)

8. AGE: Years 43 Months 1 Days 8 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Bohuslav Cerny
13. Birthplace Czechoslovakia 6 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lillian Kalal
15. Birthplace St. Louis, Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant Lillian Cerny
(b) Address 2009 Nebraska Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/44 (Month) (Day) (Year)
(c) Place: burial or cremation Sun Set Park

18. (a) Signature of funeral director W. E. Mayall
(b) Address 1926 Allen Ave.

19. (a) JAN 22 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 21 year 1944 hour 11 minute A. M.

21. I hereby certify that I attended the deceased from Sept. 1941, 19..., to Jan. 21, 1944, 19...; that I last saw her alive on Jan. 21, 1944, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fusing of the right lymph nodes, July, and anemia.	1943
Due to Hodgkins disease,	Sept. 1941.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Diagnosis-confirmed by biopsy of cervical gland.
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) (e) Means of injury

23. Signature [illegible] M.D.
Address 320 Metropolitan Bldg. Date signed 1/21/44

(Licensed Embalmer's Statement on Reverse Side)

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 ma

....., Registered Apprentice No.....

working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 allen a

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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