

MAY 9 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3833

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:  
4131a Kennerly Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community Over 40 years (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Eugenia L. 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, Widowed

6. (b) Name of husband or wife Isaac 6. (c) Age of husband or wife if alive Dec 7 years

7. Birth date of deceased December (Month) 15 (Day) 1873 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>4</u>	<u>5</u>	.....hr. ....min.

9. Birthplace Metropolis, Illinois  
(City, town, & county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER {  
 12. Name John Jones  
 13. Birthplace unavailable, Mississippi  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Hattie Pillow  
 15. Birthplace Unavailable, Tennessee  
 (City, town, or county) (State or foreign country)

16. (a) Informant Hettie Humphrey

(b) Address 4131a Kennerly

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

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

(b) Address 4107 Finney Avenue

19. (a) APR 25 1944 (b) J. F. Bredek  
(Date received local registration) (Registrar's signature)

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") 1711  
(d) Street No. 4131a Kennerly Avenue (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20  
year 1944 hour 0 minute 45 P. M.

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

Immediate cause of death  
Chronic Myocarditis  
Chronic Intestinal Preperforation  
Due to.....  
Due to.....  
Other conditions (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 3

23. Signature Thomas F. Callahan (M.D. or other) 3  
Address Deputy Coroner Date signed 4-27-44

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

59  
00  
17

**STATEMENT BY LICENSED EMBALMER**

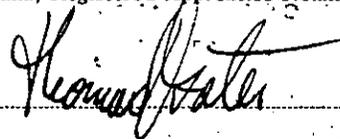
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Thomas J. Gates

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed: \_\_\_\_\_



Licensed Embalmer No. 4259

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, fact should be so stated above.**