

FILED MAR 5 1945

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 643

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Manchester  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Manchester Nursing Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Lulu Smith

3. (b) If veteran, name war Nil 3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased August 8 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
81 6 16 hr. min.

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

10. Usual occupation Music Teacher

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

12. Name Charles Parks

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

14. Maiden name Unknown

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

16. (a) Informant Ralph Smith

(b) Address Ste. Genevieve, Mo.

17. (a) Removal (b) Date thereof 2-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Denver, Colorado

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) FEB 26 1945 (b) Dr. E. J. McShanahan  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ste. Genevieve  
(c) City or town Ste. Genevieve  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24  
year 1945 hour 8:30 minute AM M.

21. I hereby certify that I attended the deceased from DEC. 1  
1943 to FEB 24, 1945;  
that I last saw him alive on DEC 22, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Due to generalized arteriosclerosis

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)  
(a) Means of injury \_\_\_\_\_

23. Signature A. J. Mathen R.P. (M. D. or nurse)  
Address 3507 P. Town Date signed 2-24-45

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

MOTHER FATHER

6006

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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..... 18601

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.**