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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22580**

FILED JUL 20 1945

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5925**

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:
Christian Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dno

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

(d) Street No. 1034A Hodiament Ave., 9
(If rural, give location)

(e) Citizen of foreign country? () (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME George W. Smith Sr.

3. (b) If veteran, name war No

3. (c) Social Security No. 490-12-9458.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
year 1945 hour 8.05 minute A.M. M.

21. I hereby certify that I attended the deceased from 7-4-45
7-6-45 1945 to 7-6-45 1945
that I last saw him alive on 7-6-45 1945
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mildred Smith

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

7. Birth date of deceased. July 2, 1893.
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage

Due to unknown

Due to _____

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

Duration 3 days

8. AGE: Years Months Days If less than one day

52 0 4 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Henry Clay Smith

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

14. Maiden name Elanore Smith

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant Mrs. Elanore Smith

(b) Address 1034A Hodiament Ave.,

17. (a) Removal (b) Date thereof July 7/45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarksville, MO.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament Ave.,

19. (a) JUL 7 1945 J. F. Prudeck
(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 at mallea (M. D. or other) MD
Address 819-ann club Bldg Date signed 7-6-45

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

Rd1 A.C. Maellies
University Club. Bldg.

FR: 4300

2-4 P.M.

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 Isy W Wilkinson
Licensed Embalmer No. 3575
P. O. Address St. Louis, Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

Registration District No. 318Primary Registration District No. 1003Aug
5905

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:

(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 NAMEGeorge W. Smither

3. (b) If veteran,
-
- name war.....

3. (c) Social Security
-
- No.....

4. Sex

m5. Color or
race..... w

6. (a) Single, widowed, married,
-
- divorced.....
- Wid

6. (b) Name of husband or wife.....

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

7. Birth date of deceased.....

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

52

hr. min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

Accountant

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

- (b) Address.....

17. (a) (Burial, cremation, or removal)

- (b) Date thereof.....

(Month) (Day) (Year)

- (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

- (b) Address.....

19. (a)

JUL 29 1945J. F. Budeck

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
 (c) City or town.....
 (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..... Day.....
-
- year..... hour..... minute..... 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.....

Duration

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 case)

(e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

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

S-22580

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