

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

22592

FILED JUL 28 1945  
Registration District No. 318 Primary Registration District No. 1005  
State File No. Registrar's No. 6305

1. PLACE OF DEATH:

(a) County St. Louis Mo.  
(b) City or town (If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Barnes Hospital, 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 27 days. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town City of St. Louis 17  
(d) Street No. 1470a Laurel Ave 6  
(If outside city or town limits, write "RURAL")  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME William Smith

3. (b) If veteran, name war No  
3. (c) Social Security No. 492-09-3404

4. Sex Male 0  
5. Color or race White  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ethel Smith  
6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Sept. 30th, 1892  
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 20  
If less than one day hr. min.

9. Birthplace Unk Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Inspector  
11. Industry or business Wagner Electric Corp

MOTHER FATHER  
12. Name Stanton Smith  
13. Birthplace Unk Arkansas  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ethel Smith  
(b) Address 1470a Laurel Ave  
Removal (b) Date thereof 7-22-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Paragould Ark

18. (a) Signature of funeral director Jos. W. Clark  
(b) Address 1125 Hodiament Ave

19. (a) JUL 21 1945 J. F. Bruders  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20  
year 1945 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from 6-24  
1945, to 7-20 1945  
that I last saw him alive on 7-20 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic heart disease

Due to: 93

Other conditions: Hypertensive cardiovascular disease

Major findings: Of operations: Of autopsy: Saddle thrombus of abdominal aorta

Duration

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) (c) Means of injury  
23. Signature: J. F. Bruders (M. D. or nurse)  
Address: Barnes Hospital, Date signed 7/21/45

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

**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 Alfred J. Boedecker

Licensed Embalmer No. 2663

P. O. Address 5934 Alpha

**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.**