DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 11 1946

State File No. 39813

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11653

1. PLACE OF DEATH:

(a) County 1528 Inge Pl

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Louis Mo

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 4 Years

2. USUAL RESIDENCE OF DEACEASED:

(a) State Mo (b) County St Louis

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

(d) Street No. 1528 Inge Place (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Nellie Smith

3. (b) If veteran, name war

3. (c) Social Security No. Widow

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 2 (Day) 1892 (Year)

8. AGE: Years 53 Months 11 Days 29 If less than one day hr. min.

9. Birthplace Homer La. (City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business Res

MOTHER FATHER

12. Name Robert Buggs

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

14. Maiden name Unavailable

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

16. (a) Informant Elmer Pace

(b) Address 1528 Inge Pl.

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

(c) Place: burial or cremation Washington Pk

18. (a) Signature of funeral director Boyd Bros

(b) Address 3704 Finney ave.

19. (a) JAN 2 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31 year 1945 hour 6:00 minute a.m.

21. I hereby certify that I attended the deceased from 12-31 1945 to 6:30 Am 12-31 1945 that I last saw her alive on 12-31 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia Lobar Pneumonia	4 days
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature A. S. Smith (M. D. or other)

Address 11 N Jefferson Date signed 12-31-45

(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 .....

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

working under my personal supervision.

Signed Harold A. Johnson

Licensed Embalmer No. 3522

P. O. Address 3704 Finney

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.

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STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11653

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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Nellie Smith

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan 2, 1892 (Month) (Day) (Year)

8. AGE: Years 53 Months 11 Days 29 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) JAN 17 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

JAN 17 1946

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 h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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.

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(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

39813