S. No. 2
—12-45
5-17-39
I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 17 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42839

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10449

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: 4060 W. Belle
(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 MISSOURI (b) County

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

(d) Street No. 4060 W. Belle
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME DAISY PORTER

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex FEMALE

5. Color or race COL.

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 6 - 10 1882
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
64	6	21	hr. min.

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

10. Usual occupation DOMESTIC

11. Industry or business

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

MOTHER
14. Maiden name MARTHA UNKNOWN
15. Birthplace NONEY WELL (City, town, or county) MO (State or foreign country)

16. (a) Informant Mrs Opal Reed
(b) Address 4060 W Belle

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-46 (Month) (Day) (Year)
(c) Place: burial or cremation WASHINGTON PARK

18. (a) Signature of funeral director A. F. Walton
(b) Address 2709 Stoddard St.

19. (a) DEC 6 1946 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 1 ST
year 1946 hour 11 o'clock minute A.M.

21. I hereby certify that I attended the deceased from 3/5 1946 to 12/1/46 1946
that I last saw her alive on 12/1/46
and that death occurred on the date and hour stated above

Immediate cause of death Cancer of Liver

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy No

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M.D. or other)

Address [signature] Date signed

(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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard C

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.