

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42980**
11028
Registrar's No.

FILED JAN 1947

318

Registration District No. _____ Primary Registration District No. **1003**

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: **City Sanitarium**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10yrs. 7mos. 25ds.**
(Specify whether
In this community **60 yrs.**
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. **5400 Arsenal St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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1317
9
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3. (a) PRINT FULL NAME **LAURA SMITH**

3. (b) If veteran, name war **None** 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife **Late Webster** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 3 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 6 19 hr. _____ min.

9. Birthplace **Cooper County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business _____

12. Name **Pete Deson**

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

14. Maiden name **Elizabeth Sumore**

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

16. (a) Informant **Clara Robinson**

(b) Address **5400 Arsenal St.**

17. (a) **Burial** (b) Date thereof **12 24 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lakewood Park Cem.**

18. (a) Signature of funeral director **Kriegshauser Und. Co.**

(b) Address **4228 So. Kingshighway Bl.**

19. (a) **DEC 23 1946** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **22**
year **1946** hour **5.10** minute **A.** M.

21. I hereby certify that I attended the deceased from **March 1st**, 19**46** to **Dec. 22**, 19**46**;
that I last saw her alive on **March 22**, 19**46**;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Chronic Myocarditis **3/1/46x**

Due to **General Arteriosclerosis** **1946x**

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 place) (e) Means of injury _____

23. Signature **Jack Madalman** (M. D. or other) _____
Address **5400 Arsenal** Date signed **1/2/46**

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

MOTHER FATHER

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.....

Edwin A. M. Herma
.....
Licensed Embalmer No. *3024*

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.