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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 42984

FILED JAN 31 1947

Registrar's No. 10967

Registration District No. Primary Registration District No.

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:  
Firmen Desloge. A  
(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 NAME Senora Smith

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Thomas C. Smith

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased: Feb 16 1916  
(Month) (Day) (Year)

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

30	10	2	hr. min.
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9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name James R. Patton

{ 13. Birthplace Bourbon Mo.  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Ethel Leek

{ 15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas C. Smith

(b) Address 4316 Oregon Av.

17. (a) Burial (b) Date thereof 12-21-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cemetery

18. (a) Signature of funeral director With B.W. do M.

(b) Address 2929 S. Jefferson Av.

19. (a) DEC 21 1946 (b) J. B. Breaux  
(Date received local jurisdiction) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 4316 Oregon Av.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18  
year 1946 hour 2 minute 15 A.M.

21. I hereby certify that I attended the deceased from 12/15, 1946 to 12/18/46, 1946;  
that I last saw her alive on 12/17/46, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to respiratory pertussis

Due to Pylonephritis

Due to Death preceded delivery

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

Major findings:  
Of operations no

Of autopsy see above

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 R. S. Wheeler (M. D. or other) \_\_\_\_\_

Address 634 N. Grand Ave. Date signed 12/20/46

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

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**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 D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 2929 Jefferson

**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.