

Registration District No. **318**

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:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 37 days  
(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. 3831 Cook  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Alphonso Smith

3. (b) If veteran, name war 220 3. (c) Social Security No. 220

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

6. (b) Name of husband or wife Alice Smith 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Mar. 1 1872  
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Unemployed

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

12. Name Floyd Smith

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

14. Maiden name Rodie ?

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

16. (a) Informant Johnny Bell Jones

(b) Address 3831 Cook Ave.

17. (a) ~~Burial removal~~ (b) Date thereof 3-6-47  
(Month) (Day) (Year)

(c) Place of burial or cremation St. Louis

18. (a) Signature of funeral director A. M. ...

(b) Address 3831 Cook Ave  
(c) (Date received local registrar) 3/4/47 (Registrar's signature) J. F. ...

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar. day 1  
year 1947 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1-22, 1947, to 3-1, 1947;  
that I last saw him alive on Mar. 1, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction Duration Undet.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: ADDITIONAL SUPPLEMENTARY INVESTIGATION REQUIRED PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Yes  
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 10

23. Signature L. B. Williams (M. D. or other) \_\_\_\_\_  
Address 2601 N Whittier Date signed 3/4/47

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 *F. M. Green*

Licensed Embalmer No. *1173*

P. O. Address *3517 S. L. L. Ave*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. March  
Registrar's No. 2233

Registration District No. 318

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:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... 38 days  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Alphonso Smith

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m. 5. Color or race B 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day, hr. min.)

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Mar 24 47 (b) J. F. Predest (Date received local registrar) (Registrar's signature)

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. 3831 Cook  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 1  
year 1947 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1-22-47 to 3-1-47  
that I last saw him alive on Mar. 1, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction  
Duration

Due to Pelvic Peritonitis secondary to Prostatic Surgery or Prob. Bladder Perforation  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....  
Of autopsy Yes

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 Daniel W. Brown (M. D. or other)  
Address 2601 N. Whittier Date signed 3/21/47

SUPPLEMENTARY

MOTHER FATHER

E. B. Williams  
2601 N. W. Fuller  
St. Paul

6969-5