

No. 2
5-43
17-39
X38671

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community Non-Resident
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96
(c) City or town JENNINGS 0
(If outside city or town limits, write "RURAL")
(d) Street No. 2526 McHARRAN 0
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Martha Smith

3. (b) If veteran, name war No 3. (c) Social Security No. NONE

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S U

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

7. Birth date of deceased JUNE 1 1874
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 28 If less than one day hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Housewife

12. Name Jessie Smith

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

14. Maiden name Caroline Nelson

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

16. (a) Informant Wlad Smith

(b) Address 10, 595 Lakeland - Overland

17. (a) BURIAL (b) Date thereof: 5-31-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SALEM, MO.

18. (a) Signature of funeral director Robert W. Hopper

(b) Address 4700 Hanover St. St. Louis

19. (a) 3-31-47 (b) Carl A. Sharp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1947 hour 11 minute 35 p.m.

21. I hereby certify that I attended the deceased from May 28, 1947, to May 29, 1947,
that I last saw her alive on May 29, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive cardiac-vascular-renal disease - encephalopathy
and uremia

Due to 1310

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

Major findings: Of operations _____

Of autopsy _____

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) _____ Means of injury _____

23. Signature W. H. Hopper M.D. (M. D. or other) _____
Address 601 Brentwood Blvd Clayton Mo Date signed 5/31/47

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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..... *W. Wilkins*

Licensed Embalmer No..... *35-75*

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.

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(b) City or town Clayton
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(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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Martha Smith
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
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 72 Months 11 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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 _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

S-16569