No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 24 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 36284

Registrar's No. 9412

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 4 days (Specify whether years, months or days)
In this community 60 yrs

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. 2801 Chouteau
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Smith
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Not Known
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. Age abt. 94 Years | Months — | Days — | If less than one day hr. min.
9. Birthplace (City, town, or country) LA. (State or foreign country)
10. Usual occupation Nil
11. Industry or business
FATHER
12. Name Dave Smith
13. Birthplace (City, town, or country) LA. (State or foreign country)
MOTHER
14. Maiden name Kattie Shepard
15. Birthplace (City, town, or country) LA. (State or foreign country)
16. (a) Informant Marie Robinson
(b) Address 2801 Chouteau
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-47 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood
18. (a) Signature of funeral director J. Weston
(b) Address 2769 Chouteau
19. (a) OCT 11 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9 year 1947 hour 4 minute 25 P M.
21. I hereby certify that I attended the deceased from Oct. 5 1947 to Oct. 9 1947 that I last saw him alive on Oct. 9 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Generalized Arteriosclerosis	Undet.
Due to	
Due to	
Other conditions Cerebral Thrombosis (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy None	

PHYSICIAN — Underline the cause of 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 Oscar L. Daniels (M. D. or other)
Address 2601 N Whitten Date signed 10/10/47

Jefferson City Printing Co.

(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 S. J. Watson

Licensed Embalmer No. 2698

P. O. Address 2769 Chouteau

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.