

No. 300
-10-47
-17-39
-1 3906

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34714**
Registrar's No. **9472**

FILED NOV 12 1948 **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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **21 days**
In this community **28 yrs.** (Specify whether 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. **12 S Channing**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **LaMore Washington Smith**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **Not given**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **27**
year **1948** hour **8** minute **30 p m.**
21. I hereby certify that I attended the deceased from **Oct. 6**, 19**48** to **Oct. 27**, 19**48**
that I last saw him alive on **Oct. 27**, 19**48**
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **--**
6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **August 2nd 1910**
(Month) (Day) (Year)

Immediate cause of death **Beri-Beri Heart Disease hypertrophy** Duration **Undet.**
Due to
Due to
Other conditions **None**
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
38 2 25 hr. min.

Major findings:
Of operations
Of autopsy **No**
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

10. Usual occupation **Laborer**

11. Industry or business **as above**

12. Name **Washington Smith**

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

14. Maiden name **Mattie Evans**

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

16. (a) Informant **Katherine Chapman**
(b) Address **129a South Channing**

17. (a) **Burial** (b) Date thereof **11/4/1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **Chas. J. Gates**
(b) Address **4107 Finney Ave**
19. (a) **NOV 1 1948** (b) **J. B. Carter**
(Date received local registrar) (Registrar's signature)

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 **Walter L. Daniels** (M. D. or other) **11/28/48**
Address **2601 N. Whittier** Date signed

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 *Thomas J. Miller*

Licensed Embalmer No. 4257

P. O. Address 4107 7th

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.