

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

MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. **34718**  
**9522**  
Registrar's No. \_\_\_\_\_

FILED NOV 12 1948 **318**  
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:  
City Hospital #1  
(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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County San  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2713-a Geyer Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mabel S. Smith  
(b) If veteran, name war None  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 31  
year 1948 hour 1:00 minute A. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced S  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 7 1889  
(Month) (Day) (Year)

Immediate cause of death  
Due to Coronary Occlusion  
Coronary Sclerosis  
Due to 94  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
59 4 24 hr. \_\_\_\_\_ min.  
9. Birthplace Decatur Ala.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_  
12. Name Ben Nelson  
13. Birthplace Shelbyville Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Fanny Melcher  
15. Birthplace Shelbyville Tenn.  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Sunshine Jordan  
(b) Address Overland, Mo. R#7 Box 738-c  
17. (a) Burial (b) Date thereof 11-11-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lake Charles Park  
18. (a) Signature of funeral director B. B. Laster  
(b) Address 2504 Woodson Rd. Overland, Mo.  
19. (a) NOV 2 1948 (b) J. B. Laster  
(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? 3  
(Specify type of place)  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Alfred H. Perry (M. D. or other)  
Address Deputy Date signed 11/21/48

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 3454

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland 14, 5

**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.**