

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

### 1968

Do not use this space.

EC'D FEB 21 1939

1. PLACE OF DEATH *Chariton* 2  
 (a) County *Chariton* Registration District No. *175*  
 (b) Township *Cockrell* Primary Registration District No. *5247* Registered No. *2*  
 (c) City..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred *79* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Robertus Love Smith*  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

### PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widowed</i>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Joan Welch Smith</i>			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>June 26 1858</i>			
7. AGE	YEARS <i>83</i>	MONTHS <i>6</i>	DAYS <i>28</i>
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
	9. Industry or business in which work was done, as saw mill, bank, etc. <i>Farmer</i>		
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation <i>L. I. &amp; C.</i>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Illinois</i>			
FATHER	13. NAME <i>Joseph Smith</i>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ill</i>		
MOTHER	15. MAIDEN NAME <i>Rachel</i>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ill.</i>		
17. INFORMANT (ADDRESS) <i>Eperett M. Cart. Haverden Mo</i>			
18. BURIAL, CREMATION, OR REMOVAL			
PLACE	<i>Haverview</i>		DATE <i>Jan 26 1939</i>
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <i>Jas M. Laughlin M. D. M. D. Margeline M. D.</i>			
20. FILED <i>1/24 1939</i> <i>W. H. Lawton</i> Local Registrar			

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 24 1939*

22. I HEREBY CERTIFY That I attended deceased from *Jan 21 1939* to *Jan 24 1939*  
 I last saw him alive on *Jan 20 1939* Death is said to have occurred on the date stated above, at *7:35 P.*  
 The principal cause of death and related causes of importance were as follows:  
*Intero Colitis*

Date of onset  
*1-20-39*

Other contributory causes of importance:  
*Carcinoma of Gall*

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? *no* Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *no*  
 If so, specify (Signed) *W. H. Billiter* M. D.  
*163* (Address) *1137 S. 1st St. M. D.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed *11/13/39*

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, James M. Laughlin, or by Dale Burch  
Registered Apprentice No. 149, working under my personal supervision.

Signed James M. Laughlin  
Licensed Embalmer No. 1274  
P. O. Address Marceline

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, above space should be left blank.

NOT RECORDED  
DATE FILED  
DISTRICT HEALTH OFFICER NO. 8  
DISTRICT FILE NUMBER  
RECEIVED  
STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
ST. LOUIS, MISSOURI

CAUSE OF DEATH in plain terms, so that it may be properly classified.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

1968 Do not use this space.

PLACE OF DEATH (a) County Chautauq (b) Township Cockrell (c) City (d) Street No. (e) Length of residence in city or town where death occurred (f) How long in U.S. if of foreign birth? 2. PRINT FULL NAME Robertus Love Smith (a) Residence, No. St.

PERSONAL AND STATISTICAL PARTICULARS 3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wed 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min. 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 13. NAME 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 15. MAIDEN NAME 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 17. INFORMANT (ADDRESS) 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19. FUNERAL DIRECTOR (ADDRESS) 20. FILED 19. Local Registrar.

MEDICAL CERTIFICATE OF DEATH 21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-24-1939 22. I HEREBY CERTIFY, That I attended deceased from 19 to 19 I last saw him alive on 19 Death is said to have occurred on the date stated above, at m. The principal cause of death and related causes of importance were as follows: Intestinal Colitis Date of onset 45 Other contributory causes of importance: Carcinoma of face left side of face involving cheek and mouth. Name of operation Date of What test confirmed diagnosis? Was there an autopsy? 23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19 Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. Manner of injury Nature of injury 24. Was disease or injury in any way related to occupation of deceased? If so, specify (Signed) H. J. Billette, M. D. (Address) Bismarck, Mo. Bismarck

SUPPLEMENTAL

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