

REC'D FEB 15 1939

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

2361

Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
(b) Township _____ Primary Registration District No. 2001 Registered No. _____
(c) City SPRINGFIELD (d) Street No. St. John's Hospital 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Joe Wayne Smithman Mrs. Wm. Reed Mrs. Wm. Reed St. Wm. Reed Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 5, 1938

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 0 7 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
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) Wentzville Mo.

FATHER 13. NAME Clarence Smithman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Massachusetts

MOTHER 15. MAIDEN NAME Ellen Clavelle
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

17. INFORMANT (ADDRESS) Wm. Reed Mrs. Wm. Reed

18. BURIAL, CREMATION, OR REMOVAL PLACE Wm. Reed Mrs. Wm. Reed DATE Jan 16 1939

19. FUNERAL DIRECTOR (ADDRESS) Wm. Reed Mrs. Wm. Reed

20. FILED Jan 15 1939 Charl A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 15 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 16 1938 to Jan 15 1939

I last saw h./m. alive on Jan 15 1939. Death is said to have occurred on the date stated above, at 11:45 P. m.

The principal cause of death and related causes of importance were as follows:

Pneumonia lobar, left side
pleuro-pulmonary patch
108

Other contributory causes of importance: Empyema left side 12-16-38

Name of operation rib resection Date of 12-17-38

What test confirmed diagnosis? X-Ray Was there an autopsy? No

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? No
If so, specify _____

(Signed) J. Terrell, M. D.

(Address) Springfield Mo

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.

STATEMENT BY LICENSED EMBALMER

I, _____ Licensed Embalmer No. _____
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Not Embalmed

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed J. H. Heman
Licensed Embalmer No. 2576

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.)