

REC'D SEP 25 1939

Registration District No. 49Primary Registration District No. 5260

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town Hammond, Missouri
(c) Name of hospital or institution: Missouri
(If outside city or town limits, write "RURAL" and name of township)(d) Length of stay: In hospital or institution _____
(Specify whether _____)In this community _____
years, months or days3. (a) PRINT FULL NAME James Smith 5303. (b) If veteran, name war _____
3. (c) Social Security No. _____4. Sex MALE 5. Color or race White
6. (a) Single, widowed, married, divorced _____6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased _____
(Month) (Day) (Year)8. AGE: Years 55 Months _____ Days _____
If less than one day _____ hr. _____ min.9: Birthplace _____
(City, town, or county) (State or foreign country)10. Usual occupation farmer

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)14. Maiden name _____
(City, town, or county) (State or foreign country)15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address _____

17. (a) _____ (b) Date thereof Jan. 25-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 54119. (a) Sept. 16 (b) Hattie G. Davis
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ozark
(c) City or town Hammond
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23
year 1939 hour 5 minute 30 am.21. I hereby certify that I attended the deceased from June 22
1939, to June 23, 1939
that I last saw him alive on June 23, 1939
and that death occurred on the date and hour stated above.Immediate cause of death Hemorrhage of the lungs, Pulmonary Tuberculosis
Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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 F. C. Meyer (M. D. or other) _____Address Almartha Mo. Date signed _____

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29856
Do not use this space.

1. PLACE OF DEATH

(a) County Charle Registration District No. 649
(b) Township Mason Primary Registration District No. 5360 Registered No. _____
(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 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

James 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
53

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) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 6-23-1939 Hattie B. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-23-1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ 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:

Date of onset _____

Other contributory causes of importance: _____

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) J.C. Meyer _____, M. D.

(Address) Almasha _____

SUPPLEMENTARY

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

