

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS
NOV 2 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35730

State File No. _____

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 128

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(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

3. (a) PRINT FULL NAME Almeda Smith 530

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Edgar Smith 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 22 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Carroll Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. INDUSTRY OR BUSINESS

MOTHER FATHER { 12. Name Eliza Guillen

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

14. Maiden name Matilda Barnett

15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elyza Smith

(b) Address Carrollton, Mo.

17. (a) Oak Hill (b) Date interred 10-29-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill

18. (a) Signature of funeral director Milton Standley

(b) Address Carrollton, Mo.

19. (a) 10/28-39 (b) Ruth Huskins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Carrollton
(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 Oct day 27
year 1939 hour 1 minute 35 PM.

21. I hereby certify that I attended the deceased from Oct 23, 1939 to Oct 27, 1939
that I last saw he alive on 10-27-39, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion 4 days

Due to _____

Due to 54

Other conditions Diabetes
(Include pregnancy within 3 months of death) 10 years

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

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 H. B. Dever (M. D. or other) _____
Address Carrollton, Mo Date signed 10/28/39

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11/7/35

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..... *Ben W Gibson*

Licensed Embalmer No. *2961*

P. O. Address..... *Carrollton W*

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.