

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

See also 8302-40
44824
Do not use this space.

1. PLACE OF DEATH
 (a) County Scott Registration District No. 2-10
 (b) Township 1 Primary Registration District No. 6666 Registered No. _____
 (c) City Commerce (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 Perry, Wilson Smith
 (a) Residence, No. Commerce, Missouri R.S.D. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Fannie Smith</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 11, 1856</u>				
7. AGE	YEARS <u>83</u>	MONTHS <u>7</u>	DAYS <u>11</u>	IF LESS than 1 day,hrs. ormin.
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. <u>Retired Blacksmith</u>			
	10. Date deceased last worked at this occupation (month and year).....		11. Total time (years) spent in this occupation.....	
12. BIRTHPLACE (CITY OR TOWN)..... <u>Chattanooga, Tennessee</u> (STATE OR COUNTRY)				
FATHER	13. NAME <u>John Smith</u>			
	14. BIRTHPLACE (CITY OR TOWN)..... <u>Unknown</u> (STATE OR COUNTRY) <u>Tenn</u>			
MOTHER	15. MAIDEN NAME <u>Unknown Tenn</u>			
	16. BIRTHPLACE (CITY OR TOWN)..... <u>Francis Perry</u> (STATE OR COUNTRY) <u>Tenn.</u>			
17. INFORMANT <u>Mrs. Kathleen Merrick</u> (ADDRESS) <u>Commerce, Missouri</u>				
18. BURIAL, CREATION OR REMOVAL PLACE <u>Historical Park Cemetery</u> DATE <u>December 22, 1939</u>				
19. FUNERAL DIRECTOR (NAME) <u>H. J. Tolch</u> (ADDRESS) <u>Sikeston, Missouri</u>				
20. FILED _____ 19 _____ Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR)	<u>December 20, 1939</u>
22. I HEREBY CERTIFY, That I attended deceased from <u>Oct 1939</u> to <u>Dec 19, 1939</u> I last saw him alive on <u>Dec 19, 1939</u> Death is said to have occurred on the date stated above, at <u>11:30am</u> . The principal cause of death and related causes of importance were as follows: <u>Arterio Sclerosis complicating cerebral hemorrhage</u> Date of onset _____	
Other contributory causes of importance: <u>1939</u>	
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 <u>U. P. Haw.</u> M. D. (Signed) <u>U. P. Haw.</u> (Address) <u>Benton, Mo.</u>	

WRITE PLAINLY, WITH UNFADING INK. 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.

RECEIVED :

District Health Officer No. 2,

District File Number 140-200

Date Filed 1-9

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 Harvey S. Johnson

Licensed Embalmer No. 3704

P. O. Address Seixton, Mo.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

44824
Do not use this space.

1. PLACE OF DEATH *Scott*

(a) County *Scott* Registration District No. *819*
 (b) Township Primary Registration District No. *6668* Registered No.
 (c) City (d) Street No.
 (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 *Perry Wilson Smith*

(a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *M* (write the word)

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

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

YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<i>83</i>	<i>7</i>	<i>11</i>	

7. AGE

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 *File 13*, 19*40* *Wm L Daugherty* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 20*, 19*39*

22. I HEREBY CERTIFY, That I attended deceased from 19..... 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) *U. P. Haw*, M. D.
 (Address) *Benton mo*

SUPPLEMENTARY

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

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.

