

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

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

44862  
Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 834

(b) Township Cape Primary Registration District No. 6097 Registered No. 46

(c) City Near Advance, Mo. (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 530 Genial Fields Smith

(a) Residence, No. Near Advance, Mo. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mollie Smith

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 24 1858

7. AGE YEARS 81 MONTHS 1 DAYS 34 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

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 Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard County Missouri

FATHER 13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

MOTHER 15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT Edgar Mc Fee (ADDRESS) Advance, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Shelburne, Mo.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Henry A. Meyer Advance, Mo.

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1939, to Dec. 18, 1939

I last saw him alive on Dec. 17, 1939. Death is said to have occurred on the date stated above, at 3 P. m.

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

Lobar Pneumonia Date of onset \_\_\_\_\_

Other contributory causes of importance: Old age & Heart old  
Prostate gland trouble

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Clinical 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? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) E. O. Masters X DO  
 (Address) Advance, Mo.

**RECEIVED**

District Health Officer No. 2,

District File Number 140-512

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, .....

Lloyd S. Morgan, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Lloyd S. Morgan

Licensed Embalmer No. 3367

P. O. Address Advocate, 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

44862

Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 834  
(b) Township Osage Primary Registration District No. 6097 Registered No. ....  
(c) City ..... (d) Street No. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. ....  
(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 Daniel Fields 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 wid  
(write the word)

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.  
81 1 24

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.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1-5 1940 D S McHee Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 18 1939

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:

Rabies Pneumonia 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) F. O. Masters, M. D.

(Address) Osage

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

SUPPLEMENTARY

