

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 461

Primary Registration District No. 3024

Registrar's No. _____

MAR 14 1940

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution: N. 23rd St. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette

(c) City or town Luxington
(If outside city or town limits, write "RURAL")

(d) Street No. N. 23rd St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME HERSHELL SMITH

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

4. Sex ma. 5. Color or race Colored 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased: Jan. 22 - 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Luxington, MO (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Robert Smith

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

14. Maiden name Angie May Radd

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

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

(b) Address Luxington, MO

17. (a) Burial (b) Date thereof Feb. 15 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or examation Luxington, MO

18. (a) Signature of funeral director W. Williams

(b) Address Luxington, MO

19. (a) Feb. 13/40 (b) Delia Bates
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14 year 1940 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from Jan. 27 1940 to Feb. 14 1940; that I last saw him alive on Feb. 12 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia
Portal Obstruction

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN

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 W. Williams (M. D. certifier)

Address Luxington MO Date signed 2/16/40

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.

1 X181

RECEIVED
District Health Officer No. 8,
District File Number 3-13-42
Date Filed

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 comply with the above constitutes grounds for revocation of license.)

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