

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14624**

Registration District No. **190**

Primary Registration District No. **4113**

Registrar's No. **19**

1. PLACE OF DEATH:

(a) County **Clark**
(b) City or town **Kahoka Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Clark**
(c) City or town **Kahoka Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Henry Smith 530**

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

4. Sex **Male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Martha Smith** 6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **Jan 1 - 1887**
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | 73 | 3 | 22 | hr. _____ min. |

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

10. Usual occupation **Cemetery Sexton**

11. Industry or business _____

12. Name **Henry Smith**

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

14. Maiden name **unknwn**

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

16. (a) Informant **Mrs. Martha Smith**
(b) Address **Kahoka Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **April 25, 1949**
(Month) (Day) (Year)

(c) Place: burial or cremation **Kahoka Co.**

18. (a) Signature of funeral director **J. R. Bridges**
(b) Address **Kahoka Mo.**

19. (a) **Apr. 25 1949** (b) **J. R. Bridges**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4th** day **23rd**
year **40** hour **2** minute **30** A.M.

21. I hereby certify that I attended the deceased from **3-1-**, 19**48**, to **4-23-**, 19**49**
that I last saw him alive on **4-23-**, 19**49**
and that death occurred on the date and hour stated above.

Immediate cause of death **pneumonia**
2060

Due to _____
Due to **118**

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? **174**
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **J. R. Bridges** (M. D. or other) _____
Address **Kahoka Mo.** Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 5-40-1048

Date Filed MAY 14 1940

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.....

April 23 - 194, Registered Apprentice No.
working under my personal supervision.

Signed Otis L. Lutting

Licensed Embalmer No. 2965

P. O. Address Ruby Mo

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.