FILED JUN 22 1940

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

18870
Do not use this space.

**1. PLACE OF DEATH**

(a) County Lawrence Registration District No. 470

(b) Township North Mt Vernon Primary Registration District No. 5633 Registered No. 57

(c) ~~City~~ Mt. Vernon, (d) Street No. Missouri State Sanatorium 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. 6 mos. 7 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** 530 Sam Scott Smith

(a) Residence, No. Mexico Missouri St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ruby M. Smith

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Sept. 8, 1916

7. AGE: Years 23 | Months 8 | Days 8 | If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Laborer
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): October 1939
11. Total time (years) spent in this occupation:

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

FATHER
13. NAME: Sylvester Smith
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Calloway County Missouri

MOTHER
15. MAIDEN NAME: Jessie Alice Scott
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cass County Missouri

17. INFORMANT (ADDRESS): E. McMichael Record Clerk Missouri State Sanatorium

18. ~~BURIAL, CREMATION,~~ OR REMOVAL
PLACE Mexico Mo DATE 5/24 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Arnold Funeral Home Mexico Mo
Orr Co. Mt Vernon Mo

20. FILED 5/24 1940 P.A. HOLMES
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 24 1940

22. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1939, to May 24, 1940 ~~xxxx~~
I last saw him alive on May 23, 1940. Death is said to have occurred on the date stated above, at 6:55 a.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Pulmonary tuberculosis | Spring 1939 |

Other contributory causes of importance:

Empyema of right chest cavity

Name of operation ..... Date of .....
What test confirmed diagnosis? X-ray 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) Maurice L. Jones, M. D.
421 (Address) Mt. Vernon, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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. 6,
District File Number 40-1381
Date Filed JUN 10 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 .....,

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

Signed George B. Orr

Licensed Embalmer No. 946

P. O. Address Mt Vernon Ill

**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.**