

FILED JUN 22 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

19669

Registration District No. 851

Primary Registration District No. 8036 6044

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Saline Salt Pore  
(b) City or town Rural Elwood  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7  
In this community 6 mo. (Specify whether years, months or days) FILL

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(c) City or town Rural Elwood  
(If outside city or town limits, write "RURAL")  
(d) Street No. Elwood twp  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8 6  
year 1940 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 5-2  
1940, to 5-6, 1940  
that I last saw her alive on 5-6, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer  
colorectum

Duration

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions:  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_

23. Signature Chas R Parsons (M. D. or other) 5-6-40  
Address Street Springs Date signed 5-6-40

3. (a) PRINT FULL NAME ALICE GIBBS SMILEY

8. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

4. Sex Female 5. Color or race Negro 6. (a) Single, ~~widowed~~, married, divorced, Widow

6. (b) Name of husband or wife Wm Smiley 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation House maid

11. Industry or business House work

12. Name Not known

13. Birthplace Not known  
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Smiley

(b) Address Street Springs Mo

17. (a) Buried (b) Date thereof May 8, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eastland Chapel

18. (a) Signature of funeral director R.C. Carter

(b) Address Street Springs Mo

19. (a) 5/7/40 (b) R.C. Carter  
(Date received by registrar) (Registrar's signature)

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

RECEIVED  
District Health Officer No. 8,  
Date Filed 6-6-40  
Last File Number

**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..... *R.C. Carter* .....

Licensed Embalmer No. *3513* .....

P. O. Address..... *Chattanooga, Tenn.* .....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19669

DEPARTMENT OF COMMUNITY  
BUREAU OF THE CENSUS  
Registration District No. 201  
793

Primary Registration District No. 6084

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Common Salt pond  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Alice Gibbs Smiley

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

4. Sex 7 5. Color or race Negro 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife Wm Smiley 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 50 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Fulton (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation House

11. Industry or business House

12. Name Unknown

13. Birthplace Unknown (City, town, county) \_\_\_\_\_ (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Walter Smiley

(b) Address Sweet Springs Mo

17. (a) Burial (burial, cremation, or removal) (b) Date thereof 5/8/1940 (Month) (Day) (Year)

(c) Place: burial or cremation Salt pond

18. (a) Signature of funeral director R. C. Carter

(b) Address Sweet Springs Mo

19. (a) 5/7/40 (Date received local registrar) (b) Al Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 6 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Emphysema  
occlusion

Due to \_\_\_\_\_  
Due to 94 B

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature Chas R Parsons (M. D. or other) \_\_\_\_\_  
Address Sweet Springs Date signed \_\_\_\_\_

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

Unable to obtain copy of Bull. 1888

R. P. Jones