

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 175

Primary Registration District No. 5247

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Rural Lockwell Twp
(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 _____
(Specify whether _____)
In this community 64 years
years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME William Frank Smith

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 Hattie L Smith 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased June 14 1876
(Month) (Day) (Year)

8. AGE: Years 64 Months 1 Days 3 If less than one day hr. _____ min. _____

9. Birthplace Chariton Co
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name William Smith

13. Birthplace Chariton Mo
(City, town, or county) (State or foreign country)

14. Maiden name Idora Hook

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

16. (a) Informant's own signature Hattie L Smith

(b) Address Hamden Mo

17. (a) Burial (b) Date thereof July 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant View

18. (a) Signature of funeral director John D. Rush

(b) Address Marcelle Mo

19. (a) 7/18/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17th
year 1940 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 7
1940 to July 17 1940
that I last saw him alive on July 7 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 2 yrs

Due to _____

Due to 19

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? 163

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

23. Signature [Signature] (M. D. or other) MD

Address Salisbury Mo Date signed 7-22-40

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. 8,
District File Number
8-5-42
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

working under my personal supervision.

Signed

John D. Busk
John D. Busk
District Health Officer No. 8,
District File Number
8-5-42
Date Filed

Licensed Embalmer No. 3805

P. O. Address

Marceline 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.