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

Registration District No. 830

Primary Registration District No. 4503

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Shelbina
(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 _____ years, months, days)

3. (a) PRINT FULL NAME Allen Harold Smith

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 1936

7. Birth date of deceased Feb 14 1940
(Month) (Day) (Year)

8. AGE: Years 4 Months 29 If less than one day hr. min.

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

10. Usual occupation at home

MOTHER FATHER

11. Industry or business _____

12. Name Raleigh M. Smith

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

14. Maiden name Flores Wearengen

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

16. (a) Informant Raleigh M. Smith

(b) Address Shelbina, Mo

17. (a) Bureau (b) Date thereof July 15-40
(Burial, exhumation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina, Mo

18. (a) Signature of funeral director William J. Barbeau

(b) Address Shelbina, Mo

19. (a) July 15-40 (b) Ruth Jayner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby

(c) City or town Shelbina
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13 year 1940 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from 11 a. m. July 13, 1940, to July 13, 1940; that I last saw him alive on July 13, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Food Poisoning Duration 21 hrs

Due to Eating infected food

Due to _____

Other conditions (include pregnancy within 3 months of death) 1937

May 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? 740

While at work? _____ (Specify type of place) (e) Means of injury 3

23. Signature R. L. Caldwell (M.D. or other) DO

Address Shelbina, Mo Date signed July 15

RECEIVED

District Health Officer No. 10

District File Number S-40-1618

Date Filed AUG 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.....

Licensed Embalmer No. 3835

P. O. Address Delaware, Md

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. 26460

Registration District No. 830

Primary Registration District No. 4503

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Shelbyville
(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..... years, months or days)

3. (a) PRINT FULL NAME Glen Darrow Smith

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Feb 14 1940
(Month) (Day) (Year)

8. AGE: Years 2 Months 4 Days 29 If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

{ 14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(Burial, cremation, or removal) (City or town) (County) (State)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) Sept 19 40 (b) Ruth Jaeger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (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.

20. DATE OF DEATH: Month July day 13
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.....

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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTAL

