DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31715

Registration District No. 177 Primary Registration District No. 5237 Registrar's No. 23

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

1. PLACE OF DEATH:

(a) County Charlton

(b) ~~City or town~~ Rural Keytesville "Twp"
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 8 Miles S.W. Keytesville 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 Charlton

(c) City or town Rural Keytesville Twp.
(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 CLEM. SMITH

3. (b) If veteran, name war NO.

3. (c) Social Security No. NONE.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife CARRIE SMITH

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased March (Month) 28 (Day) 1854 (Year)

8. AGE: Years 86 Months 5 Days 17 If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Illinois (State or foreign country) 1

10. Usual occupation Contractor 9

11. Industry or business ____ 9

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

MOTHER
14. Maiden name Not known
15. Birthplace Not known (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. James M. Smith
(b) Address 4156 Flora Pl. St Louis

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-40 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove St. Louis Mo

18. (a) Signature of funeral director Hyde & Garrett
(b) Address Keytesville Mo

19. (a) 9-14-40 (Date received local registrar) (b) Mrs Ray Sandrin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 13 year 1940 hour 9 minute 15 A. M.

21. I hereby certify that I attended the deceased from May 20, 1940, to September 13, 1940 that I last saw h____ alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	14 hrs
Due to Ch myocarditis	Don't know
Due to acute mucous colitis	6 days
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? ____ (e) Means of injury ____

23. Signature Carl C. Weger (M. D. or other) 1
Address Keytesville Mo Date signed 9/14/40

(Licensed Embalmer's Statement on Reverse Side)

92C

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-8-40

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 H. D. Barnett

Licensed Embalmer No. 3046

P. O. Address Keytesville Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

o. 2B
-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31715

Registration District No. 171 Primary Registration District No. 5237 Registrar's No.

1. PLACE OF DEATH:
(a) County Chariton
(b) City or town Keytesville (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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME Clem 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 wd
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 86 Months 5 Days 17 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 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 Hypostatic Pneumonia (Lobar pneumonia) — Duration
Due to Chr. Mitral Carditis
Due to acute mucous Colitis
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? (e) Means of injury

23. Signature Carl C. Wegen (M. D. ~~coroner~~)
Address Keytesville, Mo. Date signed 11/19/40

SUPPLEMENTARY