

OCT 1 - 1940

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

31879  
Do not use this space.

1. PLACE OF DEATH

(a) County Darwin Registration District No. 254  
(b) Township Marion Primary Registration District No. 535  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ 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. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 12

2. PRINT FULL NAME William E. Smith

(a) Residence, No. Darwin Co. Mo. 195 #2 St. \_\_\_\_\_ # 2  
(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWER

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ella Smith (Deceased)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-7-1858

7. AGE YEARS 81 MONTHS 9 DAYS 18 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. Retail Farmer  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo

13. NAME Samuel T. Smith

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ind

15. MAIDEN NAME Sarah Ann Fr azier

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ind

17. INFORMANT (ADDRESS) G. S. Grome 2231 Pattonsburg, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Civilbend C DATE 8/27/40 19. \_\_\_\_\_

19. FUNERAL DIRECTOR (NAME) G. S. Grome R231 (ADDRESS) Pattonsburg, Mo.

20. FILED Sept 10, 1940 Francis C Sutton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/25/40 1940

22. I HEREBY CERTIFY, That I attended deceased from May 30, 1940 to Aug 25, 1940

I last saw him alive on Aug 25, 1940 Death is said to have occurred on the date stated above, at \_\_\_\_\_ m. The principal cause of death and related causes of importance were as follows:

Date of onset \_\_\_\_\_  
Filed Registration  
J. H. ...  
92 W  
Other contributory causes of importance:  
Cerebral Hemorrhage.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) John J. ... M. D.  
(Address) Pattonsburg, Mo.

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.

*[Faint, illegible text, possibly a stamp or signature, located in the upper left quadrant of the page.]*

**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 *Blommer*

Licensed Embalmer No. 2857

P. O. Address Pattonsburg, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **31879**

Registration District No. **234**

Primary Registration District No. **5358**

Registrar's No. **12**

1. PLACE OF BIRTH:

(a) County **Davess**  
(b) City or town **Marion**  
(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

**Wm E. 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 **wid**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

**Nov -**

**7 1858**

8. AGE: **81**

Years

**9**

Months

**18**

Days

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 \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **Nov 25-1940** (b) **W. E. Storer**

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Daviness**  
(c) City or town **Rural**  
(If outside city or town limits write "RURAL")  
(d) Street No. **R.F.D # 2**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **8** day **25**  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ 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 **W. H. Parker** (M. D. or other) \_\_\_\_\_

Address **Pittsburg** Date signed \_\_\_\_\_

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

SUPPLEMENTARY

