No. 2
11-10-39
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 25 1940

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 35471

Registration District No. 384 Primary Registration District No. 5535 Registrar's No.

**1. PLACE OF DEATH:**

(a) County Howell

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

(c) Name of hospital or institution:
Rt. 2, West Plains, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 4 months
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Howell

(c) City or town Rural
(If outside city or town limits write "RURAL")

(d) Street No. Rt. 2, West Plains, Mo.
(If rural, give location)

0

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William Truman 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

6. (b) Name of husband or wife

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

7. Birth date of deceased May 6, 1940 (Month) (Day) (Year)

8. AGE: Years | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Howell County (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation 0

11. Industry or business 1

FATHER
12. Name Cecil Smith
13. Birthplace Howell County (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Ollie Jackson
15. Birthplace Williston (City, town, or county) N. Dakota (State or foreign country)

16. (a) Informant Cecil Smith
(b) Address West Plains, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23/40 (Month) (Day) (Year)
(c) Place: burial or cremation Mackey Cemetery

18. (a) Signature of funeral director Lawrence Carr
(b) Address West Plains Mo 34

19. (a) 10-10-40 (Date received local registrar) (b) Vida W Simons (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 22
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from Aug. 5, 1940, to Sept. 8, 1940, that I last saw im alive on Sept. 2, 1940, and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Gastro-Interitis, acute | 48 hrs |
| Due to Infection of stomach and bowels, acute | |
| 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? (e) Means of injury

23. Signature A. H. Thornburgh, M.D. (M. D. or other) 1
Address West Plains, Mo. Date signed 10/10/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 10401092
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 _____, Registered Apprentice No. _____ working under my personal supervision.

Signed Laurence Carr

Licensed Embalmer No. 4031

P. O. Address _____

**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.**