

Registration District No. **282**Primary Registration District No. **62401**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **DUNKLIN**
 (b) City or town **UNION**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **Home**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community **most of life**
 years, months or days _____

3. (a) PRINT
FULL NAME**BEN H. 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 **Dora Smith**
 6. (c) Age of husband or wife if alive **52** years
 7. Birth date of deceased **July 22 - 1988**
 (Month) (Day) (Year)

8. AGE: Years **52** Months **4** Days _____
 If less than one day _____ hr. _____ min.

9. Birthplace **Ill.**
(City, town, or county) (State or foreign country)10. Usual occupation **Labor**

11. Industry or business

12. Name **David Smith**13. Birthplace **Ill.**
(City, town, or county) (State or foreign country)14. Maiden name **Wick**15. Birthplace _____
(City, town, or county) (State or foreign country)16. (a) Informant **Wife Dora Smith**(b) Address **Campbell Mo.**17. (a) **Burial** (b) Date thereof **11-24-48**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Campbell Elwellham**18. (a) Signature of funeral director **Landers Funeral Home**(b) Address **Campbell Mo.**19. (a) **11/22/1940** (b) **E. Landers**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dunklin**
 (c) City or town **Campbell "Rural"**
 (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 **Nov.** day **22**
 year **1940** hour **1** minute **30 A.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 **Fracture of Skull**
 Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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? _____

(e) **While at work?** (Specify type of place) _____
(e) Means of injury _____23. Signature **John P. Brown** (M. D. or other) _____Address **Campbell Mo.** Date signed _____

FILED DEC 10 1940

X22159

1940

RECEIVED

District Health Officer No. 2,

District File Number 1240-173

Date Filed 12/3/40

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.....

Licensed Embalmer No.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38636

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 282

Primary Registration District No. 5401

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Dunklin
(b) City or town Union T.P.
(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 Ber H. 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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 52 Months 4 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 _____

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 22
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

fracture of skull

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 21 D m
21

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) accident

(b) Date of occurrence November 21 1940

(c) Where did injury occur? Campbell Dunklin Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Near his home on U.S. Highway 62
(Specify type of place)

While at work? _____ (e) Means of injury struck by car. in road

23. Signature John L. Brown (M. D. or other) MD

Address Campbell Mo Date signed 1/29/41

SUPPLEMENTAL

