

FILED JAN 5 1949

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

43385
Do not use this space.

1. PLACE OF DEATH Douglas Ozark
(a) County Douglas Registration District No. 649
(b) Township Noble Primary Registration District No. 6288
(c) City Noble (d) Street No. _____ Registered No. _____
(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. da.
2. PRINT FULL NAME Charles Rupert Smith
(a) Residence, No. Noble Mo. R.R. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 20, 1940

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
) 0 7

OCCUPATION 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.
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) Noble

FATHER 13. NAME Rupert H. Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Almartha, Missouri

MOTHER 15. MAIDEN NAME Bernice Lamb

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Girdner, Missouri

17. INFORMANT (ADDRESS) Rupert Smith
Noble, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Wasola DATE 12-28-40

19. FUNERAL DIRECTOR (ADDRESS) Friends

20. FILED 19 1 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) December 27, 1940

22. I HEREBY CERTIFY, That I attended deceased from 20 1940 to Dec 27, 1940

I last saw him alive on Dec 26, 1940. Death is said to have occurred on the date stated above, at 8: A. m.

The principal cause of death and related causes of importance were as follows:

Brain injury due to
depressed lobar Date of onset Dec 27/40

Other contributory causes of importance: 168 1/2

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

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 depressed lobar
Nature of injury probably cerebral hemorrhage

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) _____ M. D.
581 (Address) _____

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.

Dr. R. M. Norman

RECEIVED

District Health Officer No. 0;

District File Number 141-3100

Date Filed JAN 8 1941

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

L. E.

No. or by, Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No.

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43386

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 6489

Primary Registration District No. 6288

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town Noble
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)

(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 Chas Rupert 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 SI

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 Months Days If less than one day
7 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 20 (Date received local registrar) (b) John J. Davis (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ozark

(c) City or town Rural Noble
(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 Dec day 27
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 _____

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 R. M. Norman (M. D. or other)

Address ava mo Date signed Dec 19

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-43386