

No. 4-1
5-17-39
I X23159

State File No. _____

APR 16 1941

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton
(c) Name of hospital or institution: Clinton Gen Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community one year
years, months or days)

3. (a) PRINT FULL NAME John C. Smith

3. (b) If veteran, name was _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race white 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 22 1869
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Steelville Ormo
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter & seaway

11. Industry or business _____

12. Name Don't know

13. Birthplace 9
(City, town, or county) (State or foreign country)

14. Maiden name Laney

15. Birthplace Jenn
(City, town, or county) (State or foreign country)

16. (a) Informant F. E. Smith

(b) Address Clinton mo

17. (a) removal (b) Date thereof 3/28-41
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Steelville mo

18. (a) Signature of funeral director Conradus Beck

(b) Address Clinton mo

19. (a) 3-31-41 (b) Dr. J. H. Hospital
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry 42
(c) City or town Clinton mo
(If outside city or town limits, write "RURAL")
(d) Street No. 422 E Franklin
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27
year 1941 hour _____ minute 3 a. M.

21. I hereby certify that I attended the deceased from March 24, 1941 to March 27, 1941; that I last saw him alive on March 26, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to _____
Due to 92W

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? 3/27
(Specify type of place) _____
While at work? (e) Means of injury _____

23. Signature W. Schubert (M. D. or other) MD
Address Clinton mo Date signed 3-27-41

Duration 4 da
PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 7.
District File Number 41-44-697
Date Filed 4/15/41

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..... J E Cousins
Licensed Embalmer No..... 1891
P. O. Address..... Clinton

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. 10980

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. _____

1. PLACE OF DEATH:

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

John C. 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 married

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive 70 years

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

8. AGE: Years Months Days If less than one day
73 4 5 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 (City, town, or county) (State or foreign country)
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) Doc. J. R. Hamblen (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry
(c) City or town Clinton mo
(If outside city or town limits, write "RURAL")
(d) Street No. E. Franklin
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 27
year 1941 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 _____

Duration

Due to _____

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?

While at work (Specify type of place) (e) Means of injury _____

23. Signature G. S. Walker (M. D. or other)
Address Clinton mo Date signed _____

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

SUPPLEMENTARY

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.