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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

22207

State File No.

FILED JUL 18 1941

Registration District No. 566 Primary Registration District No. 5765 Registrar's No. 70

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Wyatt (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Gen. Del. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 6 mo 19 da years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mississippi

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

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Gracie Mae Smith

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife —

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

7. Birth date of deceased Dec (Month) 27 (Day) 1940 (Year)

8. AGE: Years 0 Months 6 Days 19 4 If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business Infant

FATHER
12. Name Allen Smith
13. Birthplace Shawneytown Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Beulah Miller
15. Birthplace Tennessee (City, town, or county) (State or foreign country)

16. (a) Informant Tom Atkison

(b) Address Wyatt

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-41 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove - Charleston

18. (a) Signature of funeral director Fair - Nunnelee Mo

(b) Address Charleston, Mo

19. (a) 6-17-41 (Date received local registrar) (b) J D Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 16 year 1941 hour 12 minute A M.

21. I hereby certify that I attended the deceased from June 16 1941, to June 16 1941; that I last saw her alive on June 16 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	4 days
Due to Whooping Cough	6 wks.
Malnutrition	7 mo.
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 Carl S. Baur MD (M. D. or other)

Address Charleston Mo Date signed 6/16/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2.
District File Number 241-9
Date Filed 7/16/41

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.