

FILED SEP 12 1941

Registration District No. 068

Primary Registration District No. 3032

Registrar's No. 269

1. PLACE OF DEATH:

(a) County Pettis
 (b) City or town Sedalia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1 400 Wilkerson
 (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

James Coleman Smith
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex MO 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Nov 14, 1865
 (Month) (Day) (Year)

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

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

10. Usual occupation Stone mason

11. Industry or business _____

12. Name Do Not Know

13. Birthplace Do not know
 (City, town, or county) (State or foreign country)

14. Maiden name Do Not Know

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

16. (a) Informant Mrs. J. C. Connor

(b) Address Sedalia MO

17. (a) Burial (b) Date thereof Sept 2, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Mr. J. H. Blinn Broz

(b) Address Sedalia MO

19. (a) Sept 2, 1941 (b) Mrs. Harry Sneed
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Pettis
 (c) City or town Sedalia
 (If outside city or town limits, write "RURAL")
 (d) Street No. 400 Wilkerson
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29
 year 1941 hour 40 minute 30 A. M.

21. I hereby certify that I attended the deceased from wound
body 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 Lebanon
typhoid fever
septicemia
 Due to _____
 Due to _____

Other conditions Prostatitis
 (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 W. J. Bishop (M. D. or other) ✓
 Address Sedalia Date signed Sept 2, 1941

Duration

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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

Handwritten notes at top left, including "D" and "1180".

Handwritten notes at top right, including "1180".

AUG 12 1951

Date Filed 9-10-51
District File Number

District Health Officer No. 8

RECEIVED

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 Robert H. Reed

Licensed Embalmer No. 3745

P.O. Address Seaside Mo

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.

Handwritten initials "H. S." and other marks at bottom right.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29070

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Petty
(b) City or town Sedalia
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James 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, wid.

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

7. Birth date of deceased Nov 14 1865
(Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 18 If less than one day _____ 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) 9-2-41 (b) Mrs. Harry Sneed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 28 Year 1941 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ 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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

JD-11-41

