FILED SEP 11 1941

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

Do not use this space.

29577

File No.

Registered No.

1. PLACE OF DEATH

County Stoddard. Registration District No. 838

Township Liberty. Primary Registration District No. 4509.

City Dexter (No. , St. Ward)

2. FULL NAME Charles - Eugene Smith

(a) Residence, No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 2-3-1854

7. AGE: YEARS 87 MONTHS 5 DAYS 24 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: None.

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): -?- Germany -

FATHER

13. NAME: Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown.

MOTHER

15. MAIDEN NAME: Unknown.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Germany.

17. INFORMANT (ADDRESS): Billie - Gaines. Dexter Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Saddlers Chapel DATE 7-28-1941

19. UNDERTAKER (ADDRESS): Watkins Undertaking Co. Dexter Mo.

20. FILED 8/19 1941 Jennie Bunton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 7-25-1941

22. I HEREBY CERTIFY, That I attended deceased from 7-26-1941, to 7-26-1941

I last saw him alive on 7-26-1941. Death is said to have occurred on the date stated above, at 9 P.m.

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

Strangulated Inguinal Hernia

122a

Other contributory causes of importance:

Senility -

Date of onset

Name of operation None. Date of

What test confirmed diagnosis? Clinical. 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

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify

(Signed) Frank LaRue, M. D.

(Address) Dexter Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor nt.

RECEIVED
District Health Office No. 2,
District File Number 941-124
Date Filed 9/8/41

S. No. 2B
1—8-21-41
I X29288

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

State File No. 29577

Registration District No. 838 Primary Registration District No. 4509 Registrar's No.

1. PLACE OF DEATH:
(a) County: Stoddard
(b) City or town: Dexter
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Stoddard
(c) City or town: Dexter
(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: Charles E. 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: Feb. 3 1854 (Month) (Day) (Year)
8. AGE: Years 87 Months 5 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
MOTHER FATHER
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) (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) 8. 19. 1941 (b) Jennie Burton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 26 day
year 1941 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.

	Duration
Immediate cause of death	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

SOUTH STATE BOARD OF HEALTH

ARD CERTIFICATE OF DEATH

State File No.....

Registration District No..... Registrar's No.....

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day.....

year.....hour.....minute.....M.

I hereby certify that I attended the deceased from.....

.....19....., to.....19.....;

I saw.....alive on.....19.....;

death occurred on the date and hour stated above.

cause of death.....

Duration

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