

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **31125**

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **10**

1. PLACE OF DEATH:
 (a) County **BUCHANAN**
 (b) City or town **ST. JOSEPH**
 (c) Name of hospital or institution: **STATE HOSPITAL No. 22**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 yrs. 1 mo. 10 ds.**
 In this community **3 yrs. 1 mo. 10 ds.**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Jackson**
 (c) City or town **Co. Home Rb Mo**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **70**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Clarence Smith**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **wid. 2**

6. (b) Name of husband or wife **(Unknown)** 6. (c) Age of husband or wife if alive **2** years

7. Birth date of deceased **1874**
 (Month) (Day) (Year)

8. AGE: Years **67** Months **7** Days **7** If less than one day hr. _____ min.

9. Birthplace **Ind. 1**
 (City, town, or county) (State or foreign country)

10. Usual occupation **machinist**

11. Industry or business _____

12. Name **Wm. Smith**

13. Birthplace **Ind. 1**
 (City, town, or county) (State or foreign country)

14. Maiden name **Susan Ayres**

15. Birthplace **Ind. 1**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Co. Cash - Jackson Co.**
 (b) Address **Rb Mo**

17. (a) **Buried** (b) Date thereof **Sept 15 1941**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **State # 2 Cem**

18. (a) Signature of funeral director **Roy Stamer**
 (b) Address **St. Joseph Mo**

19. (a) **Sept. 15. 1941** (b) **[Signature]**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept**, day **14**, year **1941** hour **7-30** minute **9** M.

21. I hereby certify that I attended the deceased from **Aug 4**, 19**39**, to **Sept 14**, 19**41** that I last saw him alive on **Sept 14**, 19**41** and that death occurred on the date and hour stated above.

Immediate cause of death **arteriosclerosis of 2 mo.**

Due to **arteriosclerosis**

Due to **45**

Other conditions **Epilepsy for several years**
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

Duration
 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 **T. J. O'Dell** (M. D. or nurse)
 Address **St. Joseph Mo** Date signed **9/14/41**

D.S. (Licensed Embalmer's Statement on Reverse Side)

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

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 *not*.....

..... Registered Apprentice No.

working under my personal supervision.

Signed

John Roy Slawey
Licensed Embalmer No. *2435*

P. O. Address *St. Joseph*

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

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