

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

FILED OCT 24 1941

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

32799
Do not use this space.

1. PLACE OF DEATH *568*

(a) County *Jasper* Registration District No. *568*

(b) Township *Shurrell* Primary Registration District No. *6149* Registered No. *27*

(c) City *Licking* (d) Street No. *1* St.

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

2. PRINT FULL NAME *Charles F. W. Smith*

(a) Residence, No. *1* St. *1* (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Lizzie Smith*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 17 1862*

7. AGE YEARS *79* MONTHS *2* DAYS *5* If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. *Machinist*

10. Date deceased last worked at this occupation (month and year) *April 1934* 11. Total time (years) spent in this occupation *52*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Chicago Ill*

13. NAME *Charles Smith*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Not known*

15. MAIDEN NAME *Not known*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *?*

17. INFORMANT (ADDRESS) *Lizzie Smith*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Williamsburg* DATE *9-23-41*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Smith & Ferguson Licking Mo*

20. FILED *9/28* 19*41* *W. J. Reed* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 22 1941*

22. I HEREBY CERTIFY, That I attended deceased from *9/20*, 19*41*, to *9/22*, 19*41*

I last saw him alive on *9/22*, 19*41*. Death is said to have occurred on the date stated above, at *9:45* a.m.

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

Coronary occlusion
Dian

Date of onset

Other contributory causes of importance: *Hypertension*

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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) *W. J. Reed*, M. D.
 (Address) *Licking Mo*

Licensed Embalmer's Statement on Reverse Side

I X14028

RECEIVED
District Registrar, Officer No. 5,
District Office Number 10511991
Date Filed

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, above space should be left blank.

STANDARD CERTIFICATE OF DEATH

State File No. 32799

Registration District No. 868

Primary Registration District No. 6149

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Dicking
(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 Missouri (b) County Texas
(c) City or town rural Sherrell
(If outside city or town limits, write "RURAL")
(d) Street No. in Dicking, Mo.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles F. W. 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 m

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

7. Birth date of deceased July 17 1862
(Month) (Day) (Year)

8. AGE: Years 79 Months 2 Days _____
If less than one day _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 903 N. 11/4 (b) N.H. Reed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 1941 year. hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Dicking

SUPPLEMENTARY

