

No. 2
4-13-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29983

State File No. _____

FILED OCT 10 1942

Registrar's No. 312

Registration District No. 47

Primary Registration District No. 3008

14
1
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Callaway

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

(c) Name of hospital or institution State Hospital No. 9
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 months 18 days
(Specify whether)

In this community same
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County PIEMISCO

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

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

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME TOM SMITH

3. (b) If veteran, name war DK

3. (c) Social Security No. DK

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 26
year 1942 hour 4 minute P M.

4. Sex male 5. Color or race col

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

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

7. Birth date of deceased April (Month) 15 (Day) 1868 (Year)

21. I hereby certify that I attended the deceased from SEPT 24, 1942, to SEPT 26, 1942
that I last saw him alive on SEPT 25, 1942
and that death occurred on the date and hour stated above.

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

74 5 11 hr. _____ min.

Immediate cause of death Myocarditis

Duration _____

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

Due to _____

Due to _____

10. Usual occupation Saloon

Other conditions 92.2
(Include pregnancy within 3 months of death)

11. Industry or business _____

Major findings: _____

12. Name DK

Of operations _____

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

Of autopsy _____

14. Maiden name DK

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

22. If death was due to external causes, fill in the following:

16. (a) Informant Records

(a) Accident, suicide, or homicide (specify) _____

(b) Address STATE HOSPITAL No. 9

(b) Date of occurrence _____

17. (a) Removal (b) Date thereof 9 29 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? _____
(City or town) (County) (State)

(c) Place: burial or cremation Columbia mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director J. B. Roberts

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

(b) Address Columbia mo

Signature J. B. Roberts (M. D. or other) MD

19. (a) 9-29-42 (b) Jesse M. Mansfield
(Date received local registrar) (Registrar's signature)

Address Fulton mo Date signed 9/26/42

1147 (Licensed Embalmer's Statement on Reverse Side)

PHYSICIAN
Underline the cause to which death should be charged statistically.

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, fact should be so stated above.