V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 10 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6918

State File No.

Registration District No. 77 Primary Registration District No. 3012 Registrar's No. 20

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution: Excelsior Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether

In this community all of life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 24

(c) City or town Rural 0 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mable Louise Smith

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female

5. Color or race w

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

6. (b) Name of husband or wife Andy Truman Smith

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Dec (Month) 7 (Day) 1919 (Year)

8. AGE: Years 24 Months 1 Days 28 If less than one day hr. min.

9. Birthplace Ray Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Hugh Clevenger
13. Birthplace Ray Co (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Frazie Crook
15. Birthplace Clay Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant Andy T. Smith

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/44 (Month) (Day) (Year)

(c) Place: burial or cremation Enon

18. (a) Signature of funeral director Claude Pritchard

(b) Address Excelsior Springs Mo

19. (a) 2-8-44 (Date received local registrar) Mrs Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feby day 5th year 1944 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 2, 1943 to Feby 5, 1944 that I last saw her alive on Feby 5, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia — Duration 7 Days

Due to Patient has had Splenic Leukemia for 4 years.

Due to Has had X Ray treatments for Past 8 months. No improvement. Had Lobar Pneumonia

Other conditions (Include pregnancy within 3 months of death) & died with sudden heart failure, after fever left

Major findings of operation

Of autopsy none made

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) X 100

(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 John F. Grace M.D. or other M.D.

Address Excelsior Springs Mo 2/7/44

1166

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 3-8-44

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 Earl Rapp

Licensed Embalmer No. 3458

P. O. Address Ex. Spgs. 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.