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5-17-39  
X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 324

FILED JUN 9 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3038

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

1. PLACE OF DEATH:

(a) County Ann

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

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

(d) Length of stay: In hospital or institution 18 hrs  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Carrollton  
(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 Clarence Smoot

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 495-05-9760

4. Sex male 5. Color or race white

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

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

7. Birth date of deceased Oct 14 1901  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17  
year 1944 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from May 17 1944 to May 16 1944  
that I last saw him alive on May 16 8:45 P.M. and that death occurred on the date and hour stated above.

8. AGE: Years 42 Months 7 Days 3  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Result of Fractures of Cranium at temporal and Junctionure of Frontal Parietal bones

Duration 20hr 40Mn

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 169-8

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

10. Usual occupation Section Laborer Santa Fe RR.

11. Industry or business \_\_\_\_\_

12. Name Wm W Smoot

13. Birthplace Callao Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Laura Perkins

15. Birthplace Callao Mo  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant Mrs Laura Smoot

(b) Address Marshall Mo

17. (a) Burial (b) Date thereof 5-20-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Olivets

18. (a) Signature of funeral director J. M. Langley

(b) Address Marshall Mo

19. (a) 5-19-44 (b) W W Cowan  
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_ 021

(b) Date of occurrence R.R. Accident

(c) Where did injury occur? Near Mendon Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Manner of injury R. Sec.

23. Signature W. D. West (M.D. or Public Health Officer)  
Address Mendon Mo Date signed 5/20/44

450

SEP 22 1944

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

*Dale Bunch*

Licensed Embalmer No.

*4088*

P. O. Address

*Marechal Mo*

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

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