

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 11 1944

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 1725

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

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1917 Suttle St
(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

3. (a) PRINT FULL NAME Douglas W Smith

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or negro 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased: Jan 2 43
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>4</u>	<u>15</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
 12. Name Samuel Smith
 13. Birthplace Monroe City Mo
(City, town, or county) (State or foreign country)
 14. Maiden name Barbara Douglas
 15. Birthplace Hannibal Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Samuel Smith
 (b) Address 1917 Suttle St

17. (a) _____ (b) Date thereof 5 22 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baptist Cem

18. (a) Signature of funeral director Geo E Roberts

(b) Address Hannibal Mo

19. (a) 5-25-44 (b) RW Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion
 (c) City or town Hannibal
(If outside city or town limits, write "RURAL")
 (d) Street No. 1917 Suttle St
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17
 year 1944 hour 1 minute 15 A.M.

21. I hereby certify that I attended the deceased from Apr 27 1944 to May 17 1944
 that I last saw him in alive on May 17-44 1944
 and that death occurred on the date and hour stated above
 Immediate cause of death _____

Myocarditis
 Due to _____
 Due to _____

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

Major findings: 93e
 Of operations _____
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 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? _____

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

23. Signature H P M Meeker (M. D. or other) MD
 Address Hannibal Date signed 5/18/44

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

Gus E Roberts

Licensed Embalmer No. *2113*

P. O. Address *Hannibal 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.