

State File No. _____

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 254

1. PLACE OF DEATH:
(a) County PETTIS
(b) City or town SEDALIA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BOTHWELL HOSPITAL
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County PETTIS 80
(c) City or town HUCHESVILLE, MO.
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____
(If rural, give location) _____
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARY RUTH SMITH
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JULY day 26
year 1944 hour _____ minute _____ M.

4. Sex FEMALE 5. Color or race WH-
6. (a) Single, widowed, married, divorced SINGLE
6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from on
July 26, 1944, to _____, 19____;
that I last saw her alive on July 26, 1944,
and that death occurred on the date and hour stated above.
Immediate cause of death Death followed
a tonsillectomy of which is unknown
Duration _____

7. Birth date of deceased: 2 - 8 - 1925
(Month) (Day) (Year)
8. AGE: Years 19 Months 5 Days 18
If less than one day _____ hr. _____ min.

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

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation NONE

Major findings:
Of operations _____
Of autopsy _____
11. Industry or business _____

12. Name WALTER L SMITH
13. Birthplace HUCHESVILLE MO
(City, town, or county) (State or foreign country)
14. Maiden name LEVE G. GEORGE
15. Birthplace LINCOLN MO
(City, town, or county) (State or foreign country)

16. (a) Informant WALTER SMITH
(b) Address HUCHESVILLE, MO
17. (a) BURIAL (b) Date thereof 7-28-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MEM-PARK

22. If death was due to external causes, fill in the following:
(c) - 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?
_____ (Specify type of place)
While at work? _____ (e) Means of injury 0

18. (a) Signature of funeral director Illiepie Fun. Home
(b) Address SEDALIA, MO.
19. (a) 7/28-44 (b) Anna Berger
(Date received local registrar) (Registrar's signature)

23. Signature W. I. Bishop (M. D. or other) _____
Address Sedalia Mo. Date signed 7-28-44

MOTHER FATHER

11501

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

3001 600 0101

RECEIVED
District Health Officer No. 6,
District File Number
Date Filed *8-1-19*

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 *L. E. Bowler*

Licensed Embalmer No. *3867*

P. O. Address *Sealair*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 274

Primary Registration District No. 2052

Registrar's No. 254

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(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

3. (a) PRINT FULL NAME Mary Ruth Smith

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Feb 4 1922
(Month) (Day) (Year)

8. AGE: Years 19 Months 5 Days _____ If less than one day _____ min.

9. Birthplace Huxley, Mo
(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) (Burial, cremation, or removal) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-28-44 (b) Pauline Beyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

25434