

State File No.

Registration District No. 33

Primary Registration District No. 3094

Registrar's No.

1. PLACE OF DEATH:

(a) County Sect Co
 (b) City or town Sikeston Mo
 (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) 1
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
 (c) City or town Rural 72
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 16 1944
 year 1944 hour 4 minute 00 A.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 159
 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?
 _____ (Specify type of place)

While at work _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature [Signature] (M. D. or other)
 Address Sikeston Mo Date signed 7-19-44

3. (a) PRINT FULL NAME Aubrey Dale Smith

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced X 0

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

7. Birth date of deceased: 7 (Month) 16 (Day) 44 (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hr. _____ min.

9. Birthplace Sikeston (City, town, or county) 0 5110 (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Aubrey Smith

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

14. Maiden name Virginia Brown

15. Birthplace Augusta Ark (City, town, or county) (State or foreign country)

16. (a) Informant Aubrey Smith
 (b) Address Matthews Rt #1 Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-44 (Month) (Day) (Year)
 (c) Place: burial or cremation Burial Home

18. (a) Signature of funeral director [Signature]
 (b) Address Sikeston Mo

19. (a) 8/6/44 (Date received by registrar) (b) Louise Largent (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 244-1108

Date Filed 8-10-44

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.....

Wm. Embalsm

Registered Apprentice No.

working under my personal supervision.

Signed *Harold Albritton*

Licensed Embalmer No. 4210

P. O. Address *Sikeston 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.