

S. No. 2
A-8-43
5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 14 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28066

State File No. _____

Registration District No. 155

Primary Registration District No. 3127

Registrar's No. 68

1. PLACE OF DEATH:

(a) County Jasper

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

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

(d) Length of stay: In hospital or institution 1 day
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 526 South Walker
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joe Smith

3. (b) If veteran, name war No data 3. (c) Social Security No. none

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

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

7. Birth date of deceased August 16, 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>11</u>	<u>16</u>	_____ hr. _____ min.

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

10. Usual occupation Common Laborer

11. Industry or business _____

12. Name S. R. Smith

13. Birthplace no data
(City, town, or county) (State or foreign country)

14. Maiden name no data

15. Birthplace no data
(City, town, or county) (State or foreign country)

16. (a) Informant Widow Nellie Smith

(b) Address Webb City, Mo.

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Hedge-Lewis

(b) Address Webb City, Missouri

19. (a) Aug. 4, 1944 (b) Mrs. Lillis Eagle
(Date received for registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2
year 1944 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from April 21, 1943 to Aug 2, 1944
that I last saw him alive on Aug. 2, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Pellagra

Due to Faulty diet

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

Major findings:
Of operations 69

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 W. M. Storn (M. D. or other) _____

Address Webb City, Mo. Date signed 8/4/44

1182 (Licensed Embalmer's Statement on Reverse Side)

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

9
6
2

44-8-650

Statement
8/11/71

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.....

Richard Gray Lewis....., Registered Apprentice No. *360*
working under my personal supervision.

Signed..... *[Signature]*.....

Licensed Embalmer No. *3859*

P. O. Address..... *[Signature]*.....

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.