

**FILED DEC 8 1944**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38507

State File No. ....

Registration District No. .... Primary Registration District No. .... Registrar's No. ....

1. PLACE OF DEATH: *Permised*  
 (a) County *Greene*  
 (b) City or town *Netherlands TWP*  
 (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 *1*  
 In this community *19 yrs*  
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED: *Permised*  
 (a) State *Missouri* (b) County *Permised*  
 (c) City or town *Rural*  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. *Netherlands TWP*  
 (If rural, give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country *n*

3. (a) PRINT FULL NAME *Perssilia Smith*  
 3. (b) If veteran, name war  
 3. (c) Social Security No.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month *Nov.* day *11*  
 year *1944* hour *5* minute *A.M.*

4. Sex *Female* 5. Color or race *Col*  
 6. (a) Single, widowed, married, divorced *married*  
 6. (b) Name of husband or wife *Emil Smith*  
 6. (c) Age of husband or wife if alive *57* years  
 7. Birth date of deceased: (Month) *8* (Day) *14* (Year) *1887*

21. I hereby certify that I attended the deceased from *10:00* to *10:00* on *Oct., 28th,* 19 *44* for *One trip or consult* that I last saw her alive on *Oct. 28,* 19 *44*; and that death occurred on the date and hour stated above.

8. AGE: Years *57* Months *2* Days *27* If less than one day hr. min.

Immediate cause of death *Probably heart failure*  
 Due to *Arteriosclerosis*

9. Birthplace *Atkins Ark.*  
 (City, town, or county) (State or foreign country)

Due to *Chronic Nephritis*

10. Usual occupation *housekeeping*

Other conditions *Unknown*  
 (Include pregnancy within 3 months of death)

11. Industry or business *home*

Major findings: Of operations

12. Name *Anderson Cater*

Of autopsy  
 Underline the cause to which death should be charged statistically.

13. Birthplace *Atkins Ark.*  
 (City, town, or county) (State or foreign country)

14. Maiden name *Perssilia Ferguson*

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

16. (a) Informant *Emil Smith*  
 (b) Address *Netherlands, Mo.*

17. (a) *Burial* (b) Date thereof *11-12-44*  
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director *Swift, Mo.*  
 (b) Address *Rayth, Mo.*

19. (a) *11/14/44* (b) *JA Smith*  
 (Date received local certificate) (Registrar's signature)

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) (c) Means of injury

23. Signature *A. A. Reelick* (M. D. or other)  
 Address *Portageville, Mo.*

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

7800

1327

11-44-267

DEC 8 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.....

Licensed Embalmer No.....

P. O. Address.....

**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.