

No. 2
M-5-43
7-5-17-39
I X36671

FILED DEC 27 1944

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **893**

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

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Springfield**
(c) Name of hospital or institution: **St. John's Hospital**
(d) Length of stay: In hospital or institution **2 Days**
In this community **8 months**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Webster**
(c) City or town **Springfield**
(d) Street No. _____
(e) Citizen of foreign country? **No.**

3. (a) PRINT FULL NAME **NANCY LOUVISA SMITH**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **Female** 5. Color or race **White** 6. (e) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **James D. Smith** 6. (c) Age of husband or wife if alive **Dec. 16, 1867**

8. AGE: Years **77** Months **8** Days **24** If less than one day _____ hr. _____ min.

9. Birthplace **Webster Co. Mo.**

10. Usual occupation **Housewife**

11. Industry or business **John William**

12. Name **John William**

13. Birthplace **Unk. Tenn.**

14. Maiden name **Plumelia Denny**

15. Birthplace **Unk. Tenn.**

16. (a) Informant **Plumelia Smith**

(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **12-9-44**

(c) Place: burial or cremation **Springfield Cemetery**

18. (a) Signature of funeral director **Kelby Derrill**

(b) Address **Springfield, Mo.**

19. (a) **12-12-44** (b) **Orville Hardy**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **7th** year **1944** hour **5:30** pm minute _____ M.

21. I hereby certify that I attended the deceased from **Dec. 6** 1944 to **Dec. 7** 1944; that I last saw her alive on **Dec. 7** 1944 and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhage, cerebral.** Duration _____

Due to **Hypertension** 210/120

Due to _____

Other condition **Fracture, neck, right femur**

Major findings: Of operations _____

Of autopsy **JLH**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (e) Means of injury **D.**

23. Signature **Amos D. Horton** (M. D. or other) **M.D.**

Address **Springfield, Mo.** Date signed **12/12/44**

6784

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 H. H. Keller.....

Licensed Embalmer No. 3334.....

P. O. Address Raymond 1210.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jars
Registrar's No. 893

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Nancy J. 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 w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased mar 16 (Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 Mar Day 16 year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____, and that death occurred on the date and hour stated above.

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above. (Immediate cause of death) _____

Due to Death was not due to accident, suicide, or homicide. Fell down at home resulting in fracture of neck of the right femur, did not cause death - it may have been
Other conditions not (Include pregnancy within 3 months of death)

Major findings: apoplexy Of operations contributing cause to Of autopsy _____

22. If death was due to external causes, fill in the following: not

(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) (2) Means of injury _____
23. Signature James D. Horton MD (M. D. or other) _____
Address Springfield Mo. Date signed 12/16/44

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1113 6 12 24

4/203

Mr. O. K. Holden
Springfield, Mass