

FILED APR 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10505

State File No. ....

Registration District No. 302

Primary Registration District No. 6042

Registrar's No. 1507

1. PLACE OF DEATH:

(a) County Ripley  
(b) City or town Oxley Mo Warner  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rural  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ripley  
(c) City or town Oxley Mo Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Warner  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Millie M. Smith

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife B. A. Smith

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased May 23 1871  
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 4  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name unknown  
13. Birthplace in county  
14. Maiden name unknown  
15. Birthplace \_\_\_\_\_

16. (a) Informant Mary A. Roberts  
(b) Address Doniphan Mo.

17. (a) Burial (b) Date thereof 1-29-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ponder Mt.

18. (a) Signature of funeral director Blackie Mortuary  
(b) Address Doniphan Mo.

19. (a) Jan 4 - 1945 (b) Bertha White  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27.  
year 1945 hour 10 minute 9 A. M.

21. I hereby certify that I attended the deceased from Oct 1944  
to Jan 27 to 1945  
that she was alive on Jan 27 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death angina pectoris  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions hypertension  
(Include pregnancy within 5 months of death)

Major findings: Of operations none  
Of autopsy none

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 H. E. White (M. D. or other) MD  
Address Doniphan Mo. Date signed 2/28/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1217

RECEIVED

District Health Officer No. 5,

District File Number 445-173

Date Filed 4-9-45

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.....

*Not Embalmed*

....., 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.**