

FILED MAY 10 1945

Registration District No. 324

Primary Registration District No. 6093

Registrar's No. 75

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Mo. State School 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Dotson Smotherman

3. (b) If veteran, name war: - 3. (c) Social Security No. -

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive 2 years (Month) (Day) (Year) June 1925

8. AGE: Years 19 Months 10 Days 24 If less than one day hr. min.

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

10. Usual occupation Sebella, Mo

11. Industry or business -

12. Name John D. Smotherman  
13. Birthplace Mountain View Mo (City, town, or county) (State or foreign country)  
14. Maiden name Branch  
15. Birthplace Mountain View Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Records Mo. State School  
(b) Address Marshall, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-28-45 (Month) (Day) (Year)  
(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director Harry Hershberger  
(b) Address Marshall Mo

19. (a) 4/26/45 (Date received local registrar) (b) Mo T.O. Weather (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 97  
(c) City or town Marshall (If outside city or town limits, write "RURAL") 0  
(d) Street No. 0 (If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country: -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1945 hour 8 P.M. minute - M.

21. I hereby certify that I attended the deceased from Jan 1 - 45 to April 26, 1945.  
that I last saw him alive on April 26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary I. B.

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) 138

Major findings: Of operations 138  
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 L.S. James, M.D. (M. D. or other) 1  
Address Marshall, Mo. Date signed 4-26-45

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

7  
0

MOTHER FATHER

1215

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5/9/4

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 Harry Hershberger  
Licensed Embalmer No. 4357  
P. O. Address Marshall 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.