

**FILED JUN 1 1945**

Registration District No. **5210**

Primary Registration District No. **5210**

Registrar's No. **10**

1. PLACE OF DEATH: **Carroll**  
(a) County **Carroll**  
(b) City or town **Hale, Mo., Stokesound Twp**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Home 5 miles north West Tina.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **XX**  
In this community **all his life.** (Specify whether years, months or days)

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Lillie M. Smith** 6. (c) Age of husband or wife if alive **June 2nd, 1872.** years  
7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years **72** Months **11** Days **0** If less than one day hr. min.

9. Birthplace **Carroll County, Missouri.** (City, town, or county) (State or foreign country)

10. Usual occupation **Farming.**

11. Industry or business

MOTHER FATHER { 12. Name **William H. Smith,**  
13. Birthplace **Ky.** (City, town, or county) (State or foreign country)  
14. Maiden name **Charity VanHorn.** (City, town, or county) (State or foreign country)  
15. Birthplace **Ky.** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Lillie M. Smith**

(b) Address **Hale, Missouri, RFD#**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5/6/1945.** (Month) (Day) (Year)

(c) Place: burial or cremation **Coloma Cem. Tina, Mo.**

18. (a) Signature of funeral director **Clifford W. Austin,**

(b) Address **Tina, Missouri.**

19. (a) **May 6, 1945** (Date received local registrar) (b) **Mrs Edger Smith** (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **2nd** year **1945** hour **9** minute **30** A.M.

21. I hereby certify that I attended the deceased from **Coroner** Call- **May 2nd, 1945.** 19

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Arteriosclerosis - sudden attack, suffering with this condition for some time.** Duration  
Other conditions **Fell Dead in Barn. Two Nights present. Due to Coronary Arteriosclerosis**

Major findings: Of operations **afa** Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury **Coroner**  
23. Signature **Clairis Ruth** (and or other) Address **Carrollton, Mo.** Date signed **5/4/45**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

APR 16 1948

**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 *Clyde W. Austin*  
.....  
Licensed Embalmer No. *3233*  
.....  
P. O. Address *Iona Missouri*

**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.**