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17-39
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FILED JUL 13 1945

State File No. _____

Registration District No. 237

Primary Registration District No. 3048

Registrar's No. 91

1. PLACE OF DEATH:

(a) County Nodaway
(b) City or town Marquette
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Francis Hosp. 11
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 1 day years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison
(c) City or town Fairfax 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1 (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LAVETAH KATE SMITH

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
year 1945 hour 3 minute 8 M. A.

21. I hereby certify that I attended the deceased from April 15, 1945, to April 2, 1945,
that I last saw him alive on April 2, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death acute myocardial failure with infarction
Due to _____

Duration

3 days

Other conditions pac. st. double
(Include pregnancy within 3 months of death)
hypertension

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Geo 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased January 19 1879
(Month) (Day) (Year)

8. AGE: Years 66 Months 4 Days 13 If less than one day hr. _____ min. _____

9. Birthplace Un known Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER

12. Name Merriveather Harris
13. Birthplace Unknown Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Emma Susan Thompson
15. Birthplace Unknown Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Harvey N. Dehaasler
(b) Address Fairfax Missouri

17. (a) Removal & Burial (b) Date thereof 6/5/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Ridge Fairfax

18. (a) Signature of funeral director Harvey N. Dehaasler

(b) Address Fairfax, Missouri

19. (a) 6-5-45 (b) Wm. Barber
(Date received local registrar) (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) (e) Means of injury ✓

23. Signature W. C. Bauman (M. D. or other) MD.
Address Fairfax Date signed 6/3/45

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

1349

OF CHICAGO

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.

RECEIVED
District Health Officer No. 11;

District File Number.....

Date Filed.....

Signed *Harwin H. Schoeler*

Licensed Embalmer No. *4162*

P. O. Address *Fairfax, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 918

Registration District No. 251

Primary Registration District No. 3048

1. PLACE OF DEATH:
(a) County nodaway
(b) City or town marionville
(If outside city or town limits, write "RURAL" and name of township)
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 _____ years, months or days
3. (a) PRINT FULL NAME La Vietan K. 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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Jan 19 (Month) (Day) (Year)

8. AGE: Years 66 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (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 _____ Year 19 hour _____ minute _____ M. _____
21. I hereby certify that I attended the deceased from _____ to _____, 19 _____ that I last saw him _____, _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident L
(b) Date of occurrence 4-17-45 L
(c) Where did injury occur? 7 miles @ Otterbein MO
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home L
While at work? ✓ (Specify type of place) (e) Means of injury Fell L
23. Signature MC Bowman (M. D. or other) MD
Address 7 miles @ Date signed 7/14/45

SUPPLEMENTARY

209102