

FILED AUG 10, 1945
Registration District No. 272

Primary Registration District No. 4403

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Steele
(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 3 yrs None
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Wanda Joyce 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 Single

6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased Feb 18 1942
(Month) (Day) (Year)

8. AGE: Years 3 Months 4 Days 16 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business -

12. Name Odie Smith

13. Birthplace Stoddard Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Late May Rodgers

15. Birthplace Clarendon Ark
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Mae Smith

(b) Address Steele MO

17. (a) Burial (b) Date thereof 7-6-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion

18. (a) Signature of funeral director Burman Thompson

(b) Address Steele MO

19. (a) 8/3/45 (b) Wendy Hamra
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard

(c) City or town Steele
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4
year 1945 hour 10 minute 00 P. M.

21. I hereby certify that I attended the deceased from July 3
1945, to July 4, 1945

that I last saw her alive on July 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia
Streptococcal

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 240

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? _____

(Specify type of place) _____ (c) Means of injury _____

23. Signature J. Chapman (M. D. or other)

Address Steele, Mo Date signed 7-7-45

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

78
30

7-45-153

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 Joe R. Small

Licensed Embalmer No. 3100

P. O. Address Blytheville Ark

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.