

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U.S. GOVERNMENT PRINTING OFFICE: 1933
STANDARD CERTIFICATE OF DEATH

FILED AUG 21 1945
Registration District No. 209 Primary Registration District No. 3043
State File No. 27933
Registrar's No. 214

1. PLACE OF DEATH:
 (a) County Marion
 (b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Residence 1213 Church
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Marion 64
 (c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")
 (d) Street No. 1213 Church 4
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) 2
 If yes, name country _____

3. (a) PRINT FULL NAME Samuel C. Smith
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Fannie Smith 6. (c) Age of husband or wife if alive 86 years
 7. Birth date of deceased April 22, 1851
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>94</u> | <u>3</u> | <u>2</u> | hr. _____ min. |

9. Birthplace Hannibal Missouri 0
(City, town, or county) (State or foreign country)
 10. Usual occupation Retired Engineer

11. Industry or business _____
 12. Name No record
 13. Birthplace No record 9
(City, town, or county) (State or foreign country)
 14. Maiden name No record
 15. Birthplace No record 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Harry Pence
 (b) Address Chicago Illinois
 17. (a) Burial (b) Date thereof 7/26/45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mount Olivet

18. (a) Signature of funeral director Wm. M. Smith
 (b) Address 902 Broadway Hannibal Missouri
 19. (a) 7-26-45 (b) Dr. E. M. Lucke
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 24
 year 1945 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 20 1945
1945 1945 and that death occurred on the date and hour stated above. 1945
 Immediate cause of death _____
Wm. M. Smith
 Due to _____
 Due to _____

Other conditions Sudden death
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 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? _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 Underline the cause to which death should be charged statistically.

23. Signature Wm. M. Smith (M. D. or other) _____
 Address Hannibal Mo Date signed 7/29/45

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed *L. T. Jackson*.....

Licensed Embalmer No. 1399.....

P. O. Address Hannibal 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. 27923
Registrar's No. 214

Registration District No. 209 Primary Registration District No. 3043

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Commercial
(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..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Samuel C. Smith

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 M

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

7. Birth date of deceased April 22 (Month) (Day) (Year)

8. AGE: Years 94 Months 3 Days 3 If less than one day..... hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (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 April year 1945 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 Myocardial Infarction

Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations..... Of autopsy..... ADDITIONAL SUPPLEMENTARY INFORMATION RECEIVED

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..... (M. D. or other)

Address..... Date signed.....

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SUPPLEMENTARY

