

S. No. 2  
4-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37321**

**FILED DEC 13 1945**  
Registration District No. **133**

Primary Registration District No. **3022**

Registrar's No. **99**

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

1. PLACE OF DEATH:  
(a) County **7 Harrison**  
(b) City or town **Bethany**  
(c) Name of hospital or institution: **Deid Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **20 days**  
In this community **all of life**  
years, months or days

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

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Will Smith** 6. (c) Age of husband or wife if alive **73** years  
7. Birth date of deceased **June 26 1880**  
(Month) (Day) (Year)

8. AGE: Years **63** Months **4** Days **20** If less than one day hr. min.

9. Birthplace **Bethany twp Vanas Co Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER  
12. Name **James Benton Burris**  
13. Birthplace **Jackson Co Ohio**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Sarah Maloney**  
15. Birthplace **Jackson Co Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Bert Smith**  
(b) Address **Bethany Mo**

17. (a) **Burial** (b) Date thereof **Nov 19 1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **MT. Olivet Cemetery**

18. (a) Signature of funeral director **Joe E. Wheeler**  
(b) Address **Bethany Mo.**

19. (a) **Nov 19 45** (b) **Zola Burris**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Harrison**  
(c) City or town **Bethany twp - Rural**  
(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 **Nov** day **16**  
year **1945** hour **7** minute **—** M.  
21. I hereby certify that I attended the deceased from **1945** 19 to **Nov 16/45** 19  
that I last saw him alive on **Nov 16** 19  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage Embolism**

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **JZW**  
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)  
(c) Means of injury **2**  
23. Signature **J. G. Reid** (M. D. or other) **DD**  
Address **Bethany Mo** Date signed **11-20-45**

503

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
District Health Officer No. 111  
District File Number  
Date Filed

**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 E. Wheeler*  
Licensed Embalmer No. 3512  
P. O. Address. *Bethany Md*

**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.**