

2. No. 2
M-243
5-17-39
I X35997

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
FILED MAR 12 1946 **STANDARD CERTIFICATE OF DEATH**

STATE BOARD OF HEALTH OF MISSOURI

State File No. **6925**

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 59

1. PLACE OF DEATH:
 (a) County: St. Francois
 (b) City or town: Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mo. State Hospital No. 4 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9 yrs. 3 mos. 1 da
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Missouri (b) County: Dunklin 94
 (c) City or town: Kennett 0
(If outside city or town limits, write "RURAL")
 (d) Street No.: Unknown 0
(If rural, give location)
 (e) Citizen of foreign country? No 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME: LINNIE ANN SMITHWICK
 3. (b) If veteran, name war: No
 3. (c) Social Security No.: None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January day 27
 year 1946 hour 6 minute 25 P. M.

4. Sex: Female / 5. Color or race: W.
 6. (a) Single, widowed, married, divorced: Unknown 9
 6. (b) Name of husband or wife: William Albert Smithwick
 6. (c) Age of husband or wife if alive: 12 years
 7. Birth date of deceased: Sept. 12 1905
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 14, 1936 19... to Jan. 27, 1946 19...
 that I last saw her alive on Jan. 27, 1946 19...
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>40</u>	<u>4</u>	<u>15</u>	hr. _____ min.

9. Birthplace: Tennessee
(City, town, or county) (State or foreign country)
 10. Usual occupation: Housewife

Immediate cause of death: Pneumonia Duration 3 days
 Due to: Fracture Surgical neck 15 days
Pneumonia
ward in Epilepsy Hospital
 Other conditions: Epilepsy & Psychosis 10 yrs
(Include pregnancy within 3 months of death)

11. Industry or business: _____
MOTHER FATHER
 12. Name: John William Low
 13. Birthplace: Tennessee
(City, town, or county) (State or foreign country)
 14. Maiden name: Minnie L. Mary Marchbanks
 15. Birthplace: Tennessee
(City, town, or county) (State or foreign country)
 16. (a) Informant: Records State Hospital No. 4
 (b) Address: Farmington, Missouri
 17. (a) Burial (b) Date thereof: Jan. 30, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: Crede Cem., Dunklin Co., Mo.
 18. (a) Signature of funeral director: Lentz Funeral Home
 (b) Address: Kennett, Missouri
 19. (a) Feb. 12, 1946 (b) Esther Rudloff
(Date received local registrar) (Registrar's signature)

Major findings:
 Of operations: _____
 Of autopsy: No 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?
 While at work? _____
(Specify type of place) (e) Means of injury
 23. Signature: James L. Smith (M. D. or other) _____
 Address: Farmington Date signed: 2/27/46

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

Health Officer No. 4
File Number 246-1850
Dated 3-11-46

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..... *McCozen*

Licensed Embalmer No. 4084

P. O. Address Farmington

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.

Registration District No. 316 Primary Registration District No. 6075

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Rural
(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 _____ years, months or days

3. (a) PRINT FULL NAME Levine A. Smithwick
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 un
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 12 (Month) 1900 (Day) 1900 (Year)

8. AGE: Years 40 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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 _____ Day 7
year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death).
Major findings:
Of operations _____
Of autopsy 1860 38

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accidents
(b) Date of occurrence Jan 9 - 1946
(c) Where did injury occur? on ward (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
State Hospital No 4 Epileptic
While at work _____ (Specify type of place) _____ (e) Means of injury Convulsion

23. Signature Burnett J. Hoctor (M. D. or other) _____
Address Farmington - Mo Date signed _____

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

5876

10/2/47

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