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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **138**

FILED APR 17 1946
Registration District No. **150** Primary Registration District No. **5572**

1. PLACE OF DEATH: **Jackson**
(a) County **Rural Prairie**
(b) City or town _____
(c) Name of hospital or institution: **Jackson County Emergency Hospital**
(If not in hospital or institution, write street number and street name)
(d) Length of stay: In hospital or institution **45 minutes**
20 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson 48**
(c) City or town **Independence 4**
1015 N. Main (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **4**
(e) Citizen of foreign country? **NO** (Yes or No) **1**
If yes, name country _____

3. (a) PRINT FULL NAME **MINNIE E SMITH**

MEDICAL CERTIFICATION

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

20. DATE OF DEATH: Month **Jan.** 19 **19**
year **1946** hour **3** day **30** minute **P.**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

21. I hereby certify that I attended the deceased from **2 April 1945** to **19 Jan 1946**
that I last saw her alive on **19 Jan 1946** and that death occurred on the date and hour stated above.
Immediate cause of death **Cerebral Hemorrhage**
Duration _____

6. (b) Name of husband or wife **Henry H. Smith** 6. (c) Age of husband or wife if alive **86** years
7. Birth date of deceased **July 13 1872**
(Month) (Day) (Year)

Due to **Arterial Hypertension**

8. AGE: Years **73** Months **6** Days **5** If less than one day hr. min.

Due to _____

9. Birthplace **Robinson Illinois**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation **Housewife**

Major findings: Of operations _____

11. Industry or business **Simpson Crocker**

Of autopsy **None**

12. Name **Unknown South Carolina**

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

13. Birthplace **Parisha Bledsoe** (State or foreign country)

14. Maiden name **Unknown Indiana**

15. Birthplace **Henry H. Smith** (State or foreign country)

16. (a) Informant **1015 N. Main**

(b) Address **Burial**

17. (a) (b) Date thereof **1-22-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
Samem Church Cemeter

(c) Place: burial or cremation **Geo. C. Carson Funeral Home**

18. (a) Signature of funeral director **Independence Missouri**

(b) Address _____

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 **[Signature]** (M. D. or other) **MD**
Address **Indep Mo** Date signed **1-22-46**

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

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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 Richard L. Lisle
~~Richard L. Lisle~~

Licensed Embalmer No. 4123

P. O. Address Indy IN

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.