No. 3
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29397

State File No.

FILED AUG 12 1946

Registration District No.

Primary Registration District No. 4536

Registrar's No.

1. PLACE OF DEATH:

(a) County WASHINGTON

(b) City or town POTOSI
(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 LIFE.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County WASHINGTON 110

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

(d) Street No. 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME BEN BLEWETT SMITH

3. (b) If veteran, name war NO.

3. (c) Social Security No.

4. Sex M.O

5. Color or race W

6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife

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

7. Birth date of deceased 8 (Month) 8 (Day) 1884 (Year)

8. AGE:

Years	Months	Days	If less than one day
62	11	25	hr. min.

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

10. Usual occupation GUARD

11. Industry or business

FATHER
12. Name CHARLES D SMITH
13. Birthplace NEW HAMPSHIRE (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ELIZA WALLACE
15. Birthplace POTOSI (City, town, or county) MO. U (State or foreign country)

16. (a) Informant LOTTIE WHITE
(b) Address POTOSI MO

17. (a) (Burial, cremation, or removal) (b) Date thereof 8-5-1946 (Month) (Day) (Year)

(c) Place: burial or cremation MASONIC

18. (a) Signature of funeral director Boger Funeral Home
(b) Address Potosi MO

19. (a) 8-27-46 (Date received local registrar) (b) Mrs G F Cresswell (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 8 day 3
year 1946 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 3, 1946 to , 19 ;
that I last saw him alive on 8 P.M. , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Date signed

337

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 846-2479

Date Filed 8-10-46

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 Mary M. Smith

Licensed Embalmer No. 4394

P. O. Address Potosi Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 366 Primary Registration District No. 4536 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Washington

(b) City or town Potosi
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Ben B. 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 Div

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 8 1884
(Month) (Day) (Year)

8. AGE: Years 62 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) Aug 27 46 (Date received local registrar) (b) Mrs. G. F. Crowell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19, to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

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)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

29397