

S. No. 2
00M-5-43
Rev. 5-17-39
I X3865

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4474**
Registrar's No. **6**

FILED MAR 10 1947

Registration District No. **109** Primary Registration District No. **4180**

1. PLACE OF DEATH:

(a) County **Dunklin**

(b) City or town **Campbell**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Home**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. **1**
(Specify whether years, months or days)

In this community **1**
years, months or days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dunklin**

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

(d) Street No. **1**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **Barbara Smith**

3. (b) If veteran, name war **---**

3. (c) Social Security No. **---**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Infant**

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

7. Birth date of deceased **October 30 1946**
(Month) (Day) (Year)

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

3 16 hr. min.

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

10. Usual occupation **---**

11. Industry or business **---**

12. Name **Carl B. Smith**

13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Vera Smith**

15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Leo Walker**

(b) Address **Campbell, Mo**

17. (a) **Burial** (b) Date thereof **2-17-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Woodlawn**

18. (a) Signature of funeral director **Anders Funeral Home**

(b) Address **Campbell, Mo**

19. (a) **2/22/47** (b) **Mrs. Beulah Campbell**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **16**
year **1947** hour **---** minute **2:30 A.M.**

21. I hereby certify that I attended the deceased from **Feb. 14**, 19**47** to **Feb 16**, 19**47**
that I last saw her alive on **Feb 16**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Whooping cough**

Due to **Whooping cough**

Due to **Pneumonia (Broncheal)**

Other conditions **---**
(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? **---**

23. Signature **D. B. L. Frankland** (Specify type of place) (g) Means of injury **---**
Address **Campbell, Mo** Date signed **2/18/47**

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

35

35

RECEIVED

District Health Office No. 2
Member 347-312
3447

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.

(Not Embalmed)

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.