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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 8 1947
187

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Livingston

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

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

(d) Length of stay: In hospital or institution 15 MINUTES (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston 59

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

(d) Street No. 2
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME "UNNAMED"

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased 3-20-1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 15 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name William Lamine Smith

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

14. Maiden name Eva Mae Barran

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

16. (a) Informant William Smith
(b) Address Braymer, MO

17. (a) Burial (b) Date thereof 3-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cowgill Cem.

18. (a) Signature of funeral director James J. Mead
(b) Address Braymer, MO

19. (a) 3-21-47 (b) Frances B. Neill
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20
year 1947 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from 5:00 PM
Mar. 20, 1947, to 5:15 PM Mar. 20, 1947
that I last saw h. m alive on 3/20/47, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Septicemia due to Placenta previa (Caesarian Section)

Due to _____

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

Major findings: Of operations 159

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? _____

While at work _____ (Specify type of place) (e) Means of injury 0

23. Signature AM Dowell (M. D. or other) 3-21-47
Address Chillicothe, MO Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *Demond J. Neal*.....

Licensed Embalmer No. *2801*.....

P. O. Address *Raymo, 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.