

S. No. 2
 MOM-2-43
 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

16755

FILED MAY 28 1947
 Registration District No. 47

Primary Registration District No. 30084068

State File No. _____

Registrar's No. 187

1. PLACE OF DEATH:
 (a) County CALLAWAY
 (b) City or town MOKANE
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(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

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County CALLAWAY 14
 (c) City or town MOKANE 0
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? NO. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Joseph C. SMART
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex MALE ^ds. Color or race White
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife CORDELIA HYNES 6. (c) Age of husband or wife if alive 65 years
 7. Birth date of deceased Dec. 12 1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 13
 year 1947 hour 11 minute 00 P. M.
 21. I hereby certify that I attended the deceased from Mar 15 1947 to April 30 1947
 that I last saw him alive on Apr. 30 1947
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>5</u>	<u>1</u>	hr. _____ min. _____

Immediate cause of death Cardiac Decompensation 6 wks
 Duration _____

9. Birthplace CALLAWAY CO. MO.
(City, town, or county) (State or foreign country)
 10. Usual occupation FARMER
 11. Industry or business _____

Due to Myocardial degeneration 5 wks
 Due to _____

12. Name ENNIS C. SMART
 13. Birthplace CALLAWAY CO. MO.
(City, town, or county) (State or foreign country)
 14. Maiden name MARY Foy
 15. Birthplace CALLAWAY CO. MO.
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
 Major findings: [Signature]
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant MRS J.C. SMART.
 (b) Address MOKANE MO

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? _____

(c) Place: burial or cremation MOKANE
 18. (a) Signature of funeral director Glen Y. Mangum
 (b) Address 912 Cent Fulton, Mo.
 19. (a) May 18 1947 (b) Joseph M. Mankoff
(Date of death) (Registrar's signature)

While at work? _____
(Specify type of) (Cause of injury)
 23. Signature John J. Brown (M. D. or other) MD
 Address FULTON Date signed 5-18-47

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

MOTHER FATHER

Date Filed 5-27-47

District File Number

District Health Officer No.

RECEIVED

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 Glen Y. Mangin

Licensed Embalmer No. 2725

P. O. Address Fulton, 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.