

FILED JUN 9 1947

Registration District No. **3017**

Primary Registration District No. **3017**

Registrar's No. **90**

1. PLACE OF DEATH:
 (a) County **Cooper**
 (b) City or town **Boonville**
 (c) Name of hospital or institution:
St. Joseph Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: **In hospital or institution 1 week**
50 Years. (Specify whether
 In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Cooper**
 (c) City or town **Bunceton, Mo.**
 (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 **Samuel T. Smith.**
 3. (b) If veteran, name war **---**
 3. (c) Social Security No. **---**
 4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Mrs. Rhoda Smith**
 6. (c) Age of husband or wife if alive **67** years
 7. Birth date of deceased **November 9, 1872**
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **May** day **30**
 year **1947** hour **8** minute **30** a. M.
 21. I hereby certify that I attended the deceased from **May 28** 19**47** to **May 30** 19**47**
 that I last saw him alive on **May 29** 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Disease, acute** Duration **2 1/2 days**
 Due to **Coronary occlusion**
 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?
 While at work? (Specify type of place) (e) Means of injury **---**
 23. Signature **W. E. Stone** (M. D. or other) **MD**
 Address **Boonville, Mo** Date signed **5-31-47**

MOTHER FATHER

8. AGE: Years Months Days If less than one day
74 **6** **21** hr. min.
 9. Birthplace **Charlottesville, Virginia.** (City, town, or county) (State or foreign country)
 10. Usual occupation **Local Manager**
Missouri Utility Co.
 11. Industry or business
 12. Name **John E. Smith**
 13. Birthplace **Virginia** (City, town, or county) (State or foreign country)
 14. Maiden name **Lucy A. Marshall** (City, town, or county) (State or foreign country)
 15. Birthplace **Virginia** (City, town, or county) (State or foreign country)
 16. (a) Informant **Benton W. Smith.**
 (b) Address **St. Louis, Mo.**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **June 1, 1947** (Month) (Day) (Year)
 (c) Place: burial or cremation **Pilot Grove Mo.**
 18. (a) Signature of funeral director **Goodman & Boller.**
 (b) Address **Boonville, Mo**
 19. (a) **5-31-47** (Date received local registrar) (b) **W. E. Stone** (Registrar's signature) **5-31**

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

RECEIVED

District Health Officer No. 8

District File Number

Date Filed 6-5-47

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 G. F. Boller

Licensed Embalmer No. 3062

P. O. Address Boswell, 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.