

No. 2
- 8-43
5-17-39
X37823

FILED SEP 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27030

State File No. _____

Registration District No. 5-8

Primary Registration District No. 4090

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Carter

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 37 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carter

(c) City or town Hunter
(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 Edith L. Smith

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1947 hour 11 minute 45 A. M.

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

6. (b) Name of husband or wife Frank Smith 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased Feb 14 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1 1947 to July 16 1947 that I last saw her alive on June 1 1947 and that death occurred on the date and hour stated above.

8. AGE: Years 74 Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death Septic pneumonia

Duration unknown

9. Birthplace College Point N. Y.
(City, town, or county) (State or foreign country)

Due to fracture of head of femur

Due to _____

10. Usual occupation House wife

Other conditions 106 18
(Include pregnancy within 3 months of death)

11. Industry or business _____

Major findings: Of operations Open reduction of femur - 6-1-47

Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

12. Name Silas Wolsey

13. Birthplace N. Y.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Frank Smith

(b) Address Ellsinore Mo. Hunter

17. (a) Hunter (b) Date thereof 7/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hunter

18. (a) Signature of funeral director Seaton Dewett

(b) Address Van Buren, 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? _____

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

23. Signature [Signature] (M. D. or D. O.)
Address Bluff Mo Date signed 7-18-47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number 8-47463

Date Filed 8-30-47

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.....

Chas S. Pewitt

....., Registered Apprentice No. 11

working under my personal supervision.

Signed Seaton Pewitt

Licensed Embalmer No. 2287

P. O. Address Van Buren 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5891
Registrar's No. 19

Registration District No. 58 Primary Registration District No. 4090

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

1. PLACE OF DEATH:
(a) County Carter
(b) City or town Hunter
(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 _____ years, months or days

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race w
6. (a) Single, widowed, married, divorced m
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

Duration _____
Due to _____
Due to _____

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

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.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace: (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace: (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 6-1-47
(c) Where did injury occur? Home (Hunter, Mo)
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - Patient fell
While at work? no (Specify type of place) (e) Means of injury Patient fell
23. Signature [Signature] (M. D. _____)
Address Payson Bluff, Mo. Date signed 6-6-47

SUPPLEMENTARY

MOTHER FATHER

27036