

FILED SEP 11 1947
333

Registration District No. **333**

Primary Registration District No. **3074**

Registrar's No. **76**

1. PLACE OF DEATH:

(a) County **Scott**
(b) City or town **Sikeston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **119 William St /**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **life** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Scott 100**
(c) City or town **Sikeston 5**
(If outside city or town limits, write "RURAL")
(d) Street No. **125 W. Trotter 2**
(If rural, give location)
(e) Citizen of foreign country? **no 0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **REVIE ROSETTA 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, **widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **Dec 29 1869**
(Month) (Day) (Year)

8. AGE: Years **77** Months **7** Days **7** If less than one day hr. _____ min. _____

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

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Emanuel Hartley**
13. Birthplace **Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Young**
15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Sallie Wainman**
(b) Address **Sikeston Mo**

17. (a) **Burial** (b) Date thereof **8-7-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sikeston Mo**

18. (a) Signature of funeral director **Wilds Funeral Home**
(b) Address **Sikeston Mo**

19. (a) **9-4-47** (b) **Mrs. F. Henry**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **5**
year **1947** hour **4** minute **00 P.**M.

21. I hereby certify that I attended the deceased from **Dec 24 1946** to **Aug 5 1947**
that I last saw him alive on **Aug 5 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Rheumatoid Arthritis; Hypertension; myocardial infarction**
Duration **2 1/2 yrs**

Due to _____
Due to _____

Other conditions: **Seizures**
(Include pregnancy within 3 months of death)
Terminated

Major findings: _____
Of operations _____
Of autopsy **gms**

540
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? **0**

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

23. Signature **J. C. McClure** (M. D. or other) **8-15-47**
Address **Sikeston, Mo** Date signed _____

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

20
5
2

SEP 24 1947

RECEIVED

District Health Office No. 2,

Medical File Number 947-1181

Date 9-9-47

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 *Raymond Crews*

Licensed Embalmer No. *3467*

P. O. Address *Lekeston 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.