

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

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Rural, Rollans Sup
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Belle Jane 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 C. A. Smith 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 22 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>4</u>	<u>9</u>	_____ hr. _____ min.

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

10. Usual occupation Housekeeping

11. Industry or business _____

12. Name David Vose

13. Birthplace New York
(City, town, or county) (State or foreign country)

14. Maiden name Susian Galphin

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

16. (a) Informant Alma Smith

(b) Address La Crosse Mo

17. (a) Burial (b) Date thereof April 2 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bevier

18. (a) Signature of funeral director M. H. McCallum
(b) Address South Gifford Mo

19. (a) Apr 10 1948 (b) Thos B. Hyper
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Macon
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. West of La Plata Mo
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 31
year 1948 hour 2 minute _____ A. M.
21. I hereby certify that I attended the deceased from July 30
1948 to March 30 1948
that I last saw her alive on March 30 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy None Requested

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) (a) Means of injury _____
23. Signature L. O. Newton (M. D. or other) _____
Address La Plata Mo Date signed 7/5/48

Duration _____
PHYSICIAN _____
Underline cause to death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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RECEIVED
District Health Officer No. 10
District File Number 44-709
Date Filed APR 15 1948

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 W. H. McCallum

Licensed Embalmer No. 2052

P. O. Address South Gifford 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. mac
Registrar's No. _____

Registration District No. 201

Primary Registration District No. 5739

1. PLACE OF DEATH:

(a) County Macou
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(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

3. (a) PRINT FULL NAME Belle J. Smith

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

4. Sex F 5. Color W race _____ 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased mu. 22 (Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____ If less than one day _____ hr. _____ min. No

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)

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 _____

MEDICAL CERTIFICATE FROM

20. DATE OF DEATH: Month mar 31
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____, that I last saw him/her on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____

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

Major findings: Of operations _____

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 _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

lobar pneumonia

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-13329