

U.S. DEPARTMENT OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

Registration District No. **184**

Primary Registration District No. **3038**

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

**1. PLACE OF DEATH:**

(a) County Pinn

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

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

(d) Length of stay: In hospital or institution 2 hrs.  
(Specify whether years, months or days)

In this community 2 years  
(Specify whether years, months or days)

**3: (a) PRINT FULL NAME** James Milton Smiser

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 single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 26 1934  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>14</u>	<u>0</u>	<u>21</u>	hr. min.

9. Birthplace Monroe Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name Milton Bryan Smiser

13. Birthplace Monroe Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Mrs. Bryan Hoffmann

15. Birthplace Monroe Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant James M. Smiser

(b) Address Marceline Mo

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

(c) Place: burial or cremation Mt. Olive

18. (a) Signature of funeral director James M. Laughlin

(b) Address Marceline Mo

19. (a) 9-20-48 (b) Walter E. Curran  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Pinn

(c) City or town Marceline  
(If outside city or town limits, write "RURAL")

(d) Street No. 523 W. Walker  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 17  
year 1948 hour 7 minute 25 P M.

21. I hereby certify that I attended the deceased from 9-2-48  
1948 to 9-17-48 1948

that I last saw him alive on Sept. 17 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death anoxemia due to pulmonary embolism Duration 3 hr.

Due to Intestinal obstruction 2 da.

Due to \_\_\_\_\_

Other conditions appendectomy 9-7-48  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 John T. Carr M. D. or other \_\_\_\_\_  
Address Marceline, Mo Date signed 9-18

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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 Blanche McLaughlin

Licensed Embalmer No. 1909

P. O. Address. Marselle, 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.**