

No. 2  
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-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 6 1949

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39750

Registration District No. 701

Primary Registration District No. 5396

State File No. \_\_\_\_\_  
Registrar's No. 58

1. PLACE OF DEATH:  
(a) County Douglas  
(b) City or town Dora, Missouri Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: No  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution No  
(Specify whether  
In this community 3 # Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Douglas  
(c) City or town Buckhart  
(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 Katie A. Smith  
3. (b) If veteran, name war NO  
3. (c) Social Security No. NO

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 7  
year 1948 hour 11 minute 30 a.m.

4. Sex F 5. Color or race W  
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. 5<sup>th</sup> 1864  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11 to 12-7, 1948.  
that I last saw her alive on 12-7 and that death occurred on the date and hour stated above.

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death myocardial degeneration  
Duration \_\_\_\_\_

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

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

10. Usual occupation Housewife

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Michael John Cauley  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Eileen Coil  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

Major findings: 93D  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant James C. Hopkins  
(b) Address Dora, Mo Route 1

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof 12-9-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation Mtn View Cemetery

(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? \_\_\_\_\_

18. (a) Signature of funeral director Duncan Funeral Home  
(b) Address Mountain View, Mo

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 2

19. (a) Dec. 27-48 (b) Westel Bushman  
(Date received local registrar) (Registrar's signature)

23. Signature Dr. J. P. Harkin (M. D. or other) D.O.  
Address Ava Mo Date signed 12-10-48

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

RECEIVED

District Health Officer No. 6,

District File Number 1248-1408

Date Filed 12-31-48

JAN 7 1949

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 *Joe S. Duncan*  
Licensed Embalmer No. *4325*  
P. O. Address *Inter View, 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.