

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10.48

FILED APR 7 1949

BIRTH NO. ... REG. DIST. NO. 240 PRIMARY REG. DIST. NO. 4357 Registrar's No. ....

1. PLACE OF DEATH a. COUNTY <i>New Madrid</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admision) a. STATE <i>Mo</i> b. COUNTY <i>New Mad</i>	
b. CITY (If outside corporate limits, write RURAL and give township) <i>Marston</i>		c. CITY (If outside corporate limits, write RURAL and give township) <i>Marston</i>	
c. LENGTH OF STAY (In this place) <i>10 years</i>		d. STREET ADDRESS (If rural, give location) <i>D</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <i>William</i> b. (Middle) <i>Henry</i> c. (Last) <i>Smith</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>March 9 1949</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov. 10, 1906</i>	9. AGE (In years last birthday) <i>42</i>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Trucking</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Trucking</i>	11. BIRTHPLACE (State or foreign country) <i>Johnson Co, Illinois</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S</i>
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13a. FATHER'S NAME <i>William George Smith</i>	13b. MOTHER'S MAIDEN NAME <i>Minda Leeley</i>	14. NAME OF HUSBAND OR WIFE <i>Nina Smith</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <i>Mrs Nina Smith</i>	ADDRESS <i>Marston, Mo</i>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pulmonary tuberculosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 years</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from *Aug 5, 1948*, to *March 9, 1949*, that I last saw the deceased alive on *March 14, 1949*, and that death occurred at *3:29 m.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Claudi W. Raven M.D.</i>	23b. ADDRESS <i>Wassonville</i>	23c. DATE SIGNED <i>March 20, 1949</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>Mar 11, 1949</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Mounds Cemetery</i>	24d. LOCATION (City, town, or county) (State) <i>Highway #61 Near Lellbourn, Mo</i>
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DATE REC'D BY LOCAL REG. <i>Mar 25, 1949</i>	REGISTRAR'S SIGNATURE <i>H. L. Gonda Deputy</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>De Lisle Funeral Parlor</i>	ADDRESS <i>Portageville, Mo</i>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2

District File Number 249-465

Date Filed 4-6-49

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed *Joseph A. DeFuria*

Licensed Embalmer No. 4287

P. O. Address *Polkville 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.