

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

38553
Do not use this space.

REC'D DEC 16 1938

1. PLACE OF DEATH

(a) County Benton Registration District No. 59
 (b) Township Williams Primary Registration District No. 5094 Registered No. 384
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 30 William Smith

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Nora Smith

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-13-1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 9 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Benton Co (STATE OR COUNTRY) Missouri

FATHER 13. NAME Jackson Smith
 14. BIRTHPLACE (CITY OR TOWN) Ill (STATE OR COUNTRY) Ill

MOTHER 15. MAIDEN NAME Elizabeth Hollond
 16. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY) Indiana

17. INFORMANT E. L. Eickhoff (ADDRESS) Cole Camp Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Linnow Branch DATE 11-24-38

19. FUNERAL DIRECTOR (NAME) E. L. Eickhoff (ADDRESS) Cole Camp Mo

20. FILED 11-23-1938 Sue Selover Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-22-38 1938

22. I HEREBY CERTIFY, That I attended deceased from 11-20-38 1938 to 11-22-38 1938
 I last saw ~~him~~ alive on 11-22-38 1938 Death is said to have occurred on the date stated above, at 9:30 P. m.
 The principal cause of death and related causes of importance were as follows:

Carcinoma of Prostate Date of onset _____
 Other contributory causes of importance: 51

Name of operation _____ Date of _____
 What test confirmed diagnosis? Biopsy Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) E. L. Eickhoff, M. D.
 (Address) Cole Camp Mo

RECEIVED
District Health Officer No. 7,
District File Number 7-38-440
Date Filed 12-5-38

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.....

E. L. Elbert

Licensed Embalmer No. 790

P. O. Address.....

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, above space should be left blank.