

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

REC'D DEC 19 1938

39397
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 3 Registration District No. 400
 (b) Township Prarie Primary Registration District No. 5359B Registered No. 236
 (c) City Prarie (d) Street No. Jackson Home St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

530 William Oswald Smith
 (a) Residence, No. 9720 Kentucky ave St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-25-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 11 15

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Coal R.P.
 9. Industry or business in which work was done, as saw mill, bank, etc. Conductor
 10. Date deceased last worked at this occupation (month and year) Oct 28 11. Total time spent in this occupation 67

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

FATHER 13. NAME James Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

MOTHER 15. MAIDEN NAME Mary Clements

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

17. INFORMANT (ADDRESS) Ernest Jackson Jackson Home

18. BURIAL OR REMOVAL PLACE DATE Wilmington 11-12-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. G. Foster R.C.M.

20. FILED 11-10-38 William J. Fields Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 10 1938

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1938 to Nov 10 1938
 I last saw him alive on 11/8 1938 Death is said to have occurred on the date stated above, at 9 A.M.
 The principal cause of death and related causes of importance were as follows:

Chronic myocarditis Date of onset 93
 Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical 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) W. J. Fields M. D.
 (Address) Independence

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.....

Licensed Embalmer No.....

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.