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.

REC'D FEB 16 1939

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

2155
Do not use this space.

1. PLACE OF DEATH
(a) County Dent
Registration District No. 1035
(b) Township Texas
Primary Registration District No. 5372
Registered No. 3
(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 Adolph DeShmedt
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Elizabeth De Shmedt
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mch 24, 1867
7. AGE YEARS 71 MONTHS 9 DAYS 20 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming
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) Jan. 1939
11. Total time (years) spent in this occupation all life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Enghien Belgium

FATHER
13. NAME Eduard DeSmedt
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Belgium

MOTHER
15. MAIDEN NAME Dent
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Know

17. INFORMANT (ADDRESS) Mrs Adolph DeSmedt Rhyse, Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Salem DATE 1/14 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm R Strencer Salem Mo.
20. FILED 1/15 1939 J. A. Kissock Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 14, 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1939, to Jan. 14, 1939
I last saw him alive on Jan. 13, 1939. Death is said to have occurred on the date stated above, at 8:30 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Double Broncho	1/10
pneumonia	39

Other contributory causes of importance: 107 W

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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) L. L. Reed, M. D.
(Address) Licking Mo.

(Licensed Embalmer's Statement on Reverse Side)

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, Carl K Spencer, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Carl K Spencer

Licensed Embalmer No. 2 3 72

P. O. Address Salem Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.