

REC'D MAR 15 1939

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

8102

Do not use this space.

1. PLACE OF DEATH

(a) County Vexdon 1 Registration District No. 875
(b) Township Washington Primary Registration District No. 6162 Registered No. 50
(c) City Nevalde (d) Street No. State Hospital #3 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 0 yrs. 2 mos. 6 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Box 2 Springfield Mo. 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 Widowed
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 5, 1878
7. AGE YEARS 61 MONTHS 5 DAYS 13 If LESS than 1 day, = hrs. or = min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk
9. Industry or business in which work was done, as saw mill, bank, etc. Groc. Store
10. Date deceased last worked at this occupation (month and year) ? 11. Total time (years) spent in this occupation ?

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

FATHER 13. NAME Thomas Smith
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER 15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT Records, State Hosp #3
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Springfield, Mo. DATE Feb 24, 1939

19. FUNERAL DIRECTOR (NAME) Ferry Funeral Home
(ADDRESS) Wenatche, Mo.

20. FILED 2-20 1939 Allen V. Mayo
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1938 to Feb. 18, 1939
I last saw him alive on Feb. 18, 1939. Death is said to have occurred on the date stated above, at 5:30 p. m.

The principal cause of death and related causes of importance were as follows:

Luetic Intracranial Hemorrhage Date of onset 2-11-39
Senility
Other contributory causes of importance: Paralysis

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ 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) Wesley H. Yocum, M. D.
793 (Address) State Hosp #3, Nevada

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

RECEIVED

District Health Officer No. _____

District File Number 7-39-40

Date Filed 3-8-39

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, Personal

or by _____

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

Signed

Lloyd R. Winsett

Licensed Embalmer No. 3857

P. O. Address Merida, Mo

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

8102
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875-
(b) Township Washington Primary Registration District No. 6162 Registered No. 50
(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

James 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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>wid</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>61</u>	MONTHS <u>5</u>	DAYS <u>13</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	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) (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19____				
19. FUNERAL DIRECTOR (ADDRESS)				
20. FILED <u>2-20</u> 19 <u>39</u> <u>Allen & Lays</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 15 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

I last saw h _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

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? _____

If so, specify _____ (Signed) Reese H. Patten, M. D.

(Address) state # 3

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

