

REC'D MAY 22 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH15550  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Missouri Registration District No. 566  
 (b) Township Waverly Primary Registration District No. 5762  
 (c) City Charleston (d) Street No. \_\_\_\_\_  
 (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.

Registered No. 35

## 2. PRINT FULL NAME

Carol Jean Smoot  
 (a) Residence, No. RFD #1 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 F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 28 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
0 0 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
 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) Charleston No. 0

FATHER 13. NAME Walter Smoot  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) East Prairie Mo.

MOTHER 15. MAIDEN NAME Mabel Gutzke  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Charleston No.

17. INFORMANT (ADDRESS) Walter Smoot RFD #1 Charleston No.

18. BURIAL, CREMATION, OR REMOVAL PLACE W. V. F. Cemetery DATE April 3 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hotel The Funeral Home Charleston No.20. FILED 4-4-39 F. D. Brown Local Registrar.MEDICAL CERTIFICATE OF DEATH 2 R.M.21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 3 193922. HEREBY CERTIFY, That I attended deceased from Mar 28 1939 to Apr 3 1939I last saw h. e. r. alive on Apr 2 1939. Death is said to have occurred on the date stated above, at 2:14 p. m.

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

Cerebral hemorrhage Date of onset Birth  
(Birth injury)  
160 lb

Other contributory causes of importance:

disproport. fetus + pelvis

Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis el. sympt. 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

(Signed) K. Chas. Calving M. D.  
Charleston, Mo. (Address)

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**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.**