

REC'D JUN 14 1939

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

20009  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Texas Registration District No. 866  
(b) Township Current Primary Registration District No. 6146  
(c) City..... (d) Street No.....  
(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

530 Charles Radis 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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 21 - 1921

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
17 4 25

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. at home  
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) Hartshorn Mo

FATHER 13. NAME Jack Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hartshorn Mo

MOTHER 15. MAIDEN NAME Archie Ball

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hartshorn Mo

17. INFORMANT (ADDRESS) Jack Smith

18. BURIAL, CREMATION, OR REMOVAL PLACE Antioch DATE 4-17 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) XX 785

20. FILED 4-17 1939 Maggie E. Murphy Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-16 1939

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

I last saw him alive about Apr. 14 1939 Death is said to have occurred on the date stated above, at 7:45 P.M.

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

Chronic Bright disease

Date of onset

Other contributory causes of importance: Flu 12/1

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) Dr. J. M. Reeds M. D.

(Address) Summersdale Mo.

*10/10/2*

*10/10/2*

*10/10/2*

*10/10/2*

**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.

*10/10/2*  
*10/10/2*  
*10/10/2*  
*10/10/2*  
*10/10/2*