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.

OCT 17 1939

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

33826
Do not use this space.

1. PLACE OF DEATH
(a) County Webster 2 Registration District No. 897
(b) Township ~~Linden~~ 1 Primary Registration District No. 4543 Registered No. 21
(c) City Seymour (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. 2 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 520 Henry S Smith
(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 M.
4. COLOR OR RACE W.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Anna Smith
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 12 1858
7. AGE YEARS 80 MONTHS 9 DAYS 1 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Reding Penn.

FATHER
13. NAME Augusta Smith
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

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

17. INFORMANT (ADDRESS) Mrs H. A. Smith Seymour Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Galloway Cem DATE 9-15 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kelley-Sewell Seymour Mo
20. FILED Sept 14 1939 R E Mahan M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 13, 1939
22. I HEREBY CERTIFY, That I attended deceased from May 2, 1939, to Sept 13, 1939
I last saw him alive on July 30, 1939. Death is said to have occurred on the date stated above, at 8.45 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Uremia	
Toxemia	
Terminal Bronchial	
Pneumonia	

Other contributory causes of importance:
1 to 3 Burns of Rt. lower extremity - Chr. Cardio. Vascular Renal Disease

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) Ronald F. Elkins, M. D.
(Address) Springfield Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File number 1039-2080
Date Filed OCT 11 1939

181

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 K K Kelley

Licensed Embalmer No. 3334

P. O. Address Seymour 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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

33826
Do not use this space.

1. PLACE OF DEATH
(a) County: Webster — Registration District No.: 897
(b) Township: — Primary Registration District No.: 4543 — Registered No.:
(c) City: Seymour — (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: Henry S. Smith
(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid

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

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

7. AGE: Years 80 — Months 9 — Days 1 — 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: 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 9-13, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
I last saw him 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
Uremia, Toxemia, Terminal Bronchial Pneumonia	8/15

Other contributory causes of importance:
1-3 Burns of rt lower extremities - chr Cardio Vascular Renal Disease

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? Accident Date of injury 5-2, 1939
Where did injury occur? At home Galloway, Mo. (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Home
Manner of injury: Car burned.
Nature of injury: 2nd & 3rd degree burns of rt. leg & arm.

24. Was disease or injury in any way related to occupation of deceased?
If so, specify:
(Signed) Ronald F. Elkins, M. D.
(Address) Springfield Mo.

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

2B
1-40
22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33826

Registration District No. 397 - Primary Registration District No. 4543 - Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Webster
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Henry Smith

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 5-31-40 (Date received local registrar) (b) R E McMahan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 13 day 39 -
year hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia toxemia
Broncho Pneu -
Chr. Cardio Vas. Renal Dis -
Due to Burns lower part of
Due to body -
Other conditions
(Include pregnancy within 3 months of death)
Major findings: Of operations # Car not in motion #
Of autopsy

Duration
81
15

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accd -
(b) Date of occurrence 5-2-9 -
(c) Where did injury occur? Home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury Car burned

23. Signature (M. D. or other)
Address Date signed