

FILED FEB 12 1940

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

1700

Do not use this space.

1. PLACE OF DEATH

(a) County Buckanan

(b) Township

(c) City St Joseph

(e) Length of residence in city or town where death occurred

Registration District No. 85Primary Registration District No. 1001(d) Street No. Junny Slope Hospital

(If death occurred in Hospital or Institution, write its name instead of street and number)

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 33

2. PRINT FULL NAME

(a) Residence, No. 5337 Betty Lou Smith1201 S. 33rd St.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FEMALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

SINGLE

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

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

Oct. 28th 1938

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

1212

OCCUPATION

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.

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)

St Joseph, Mo.

FATHER

13. NAME

Don Smith

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

St. Joseph, Mo.

MOTHER

15. MAIDEN NAME

Louise Floyd

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

St Joseph, Mo.

17. INFORMANT (ADDRESS)

Mr. Don Smith
1201 S. 33rd St. Joseph, Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE ASHLANDDATE 1-12-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

FLEEMAN & SON, INC.
1946 Calhoun St. Joseph, Mo.

20. FILED

Jan 11 1940 AJ. Nuttlebaum
Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

JAN. 10th 1940

22. I HEREBY CERTIFY, That I attended deceased from

12-30-1939, to 1-10-1940I last saw him alive on 1-10-1940. Death is saidto have occurred on the date stated above, at 10:50 P.M.

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

Meningitis, spinal et cerebral
Date of onset Oct. 12/1939

Other contributory causes of importance:

Bronchitis
Sept. SepsisName of operation none Date of noneWhat test confirmed diagnosis? Pathological Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? no Date of injury no, 19Where did injury occur? no

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury noneNature of injury none24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W. E. Ginnies, M. D.(Address) St Joseph, Mo.

1742

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 C. G. Swan

Licensed Embalmer No. 4082

P. O. Address St. Joseph, Mo.

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.

