

## STANDARD CERTIFICATE OF DEATH

State File No. 5059

FEB MAR 12 1940

Registrar's No. 1889Registration District No. 791 Primary Registration District No. 1003

## 1. PLACE OF DEATH:

- (a) County 1  
 (b) City or town St. Louis, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Mo. Baptist Hospital  
 (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 days3. (a) PRINT FULL NAME 530 Anna Smith3. (b) If veteran, name war No. 3. (c) Social Security No. None4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Henry Smith 6. (c) Age of husband or wife if alive 67 years7. Birth date of deceased Oct. 27 1867  
 (Month) (Day) (Year)8. AGE: Years 72 Months 3 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Tenn.  
 (City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name Henry Haislip  
 { 13. Birthplace Tenn.  
 (City, town, or county) (State or foreign country)  
 { 14. Maiden name Elizabeth Walls  
 { 15. Birthplace Tenn.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Henry Smith(b) Address Bourbon, Mo.17. (a) Removal (b) Date thereof 2-25-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Bourbon, Mo.18. (a) Signature of funeral director Albert H. Hoppe(b) Address 4700 Washington Ave.19. (a) FEB 24 1940 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford(c) City or town Bourbon  
 (If outside city or town limits, write "RURAL") NR(d) Street No. \_\_\_\_\_  
 (If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 Feb 22  
 year 1940 hour 3 PM minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from 2-16  
 \_\_\_\_\_, 19 40 2-22, 19 40that I last saw her alive on Feb 22, 19 40  
 and that death occurred on the date and hour stated above.Immediate cause of death Carcinoma  
of sigmoid colon Indefinite

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)Major findings: Carcinoma Sigmoid

Of operations \_\_\_\_\_

Of autopsy none made

Duration

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) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature John D. Haywood (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

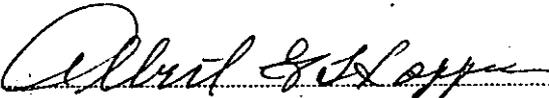
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**STATEMENT BY LICENSED EMBALMER**

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..... 2971

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.**