

FILED MAR 11 1940

Registration District No.

Primary Registration District No. 5-401

Registrar's No.

1. PLACE OF DEATH:

(a) County Dunklin Mo
(b) City or town Union Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether most of life)
In this community most of life
years, months or days 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town near Campbell Rural
(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 THOMAS FRANK SMITH

3. (b) If veteran, name war no 3. (c) Social Security No. 700

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased Sept 21 - 1860
(Month) (Day) (Year)

8. AGE: Years 65 Months 4 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Ill
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Frank Smith

13. Birthplace Ill
(City, town, or county) (State or foreign country)

14. Maiden name Madison

15. Birthplace Ill
(City, town, or county) (State or foreign country)

16. (a) Informant Son Frank Smith

(b) Address Campbell Mo.

17. (a) Burial (b) Date thereof Feb 12 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Visitation

18. (a) Signature of funeral director Landess + Son

(b) Address Campbell Mo.

19. (a) Feb 12 - 40 (b) Wallace Belsay
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 12 day _____
year 1940 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from June 8 1939, 1939, to _____, 19____; that I last saw him alive on June 8 1939, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Stomach

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: none
Of operations none
Of autopsy none

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 Wallace Belsay (M. D. or other) 1

Address Campbell, Mo. Date signed 2/2/40

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

35

RECEIVED

District Health Officer No. 2

District File Number 340-69

Date Filed 3/6/40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 65-287

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 282

Primary Registration District No. 3401

Registrar's No.

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

1. PLACE OF DEATH:

(a) County... Dunklin

(b) City or town... Union Jcs
(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.....
In this community..... (Specify whether years, months or days)

3. (a) **PRINT FULL NAME** Thomas Frank 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 urd

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive.....

7. Birth date of deceased sept 21 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 4 21 hr. min.

9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace.....
(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Feb 12 1940 (b) W. E. Warden
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 12
year 1940 hour..... minute..... M.

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

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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 Wallace A. Beboey

Address Campbell

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

