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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

MAY 26 1940

Registration District No. 496 — Primary Registration District No. 3025 — Registrar's No. 38

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Brookfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 497 E. Clark (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days) In this community 33 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Linn

(c) City or town: Brookfield (If outside city or town limits, write "RURAL")

(d) Street No. 497 E. Clark (If rural, give location)

(e) If foreign born, how long in U. S. A.? 33 years.

3. (a) PRINT FULL NAME: William Harry 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: Widowed

6. (b) Name of husband or wife: Flora Agnes Smith 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Feb. (Month) 22 (Day) 1870 (Year)

8. AGE: Years 70 Months 2 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation: Retired Farmer

11. Industry or business: _____

FATHER 12. Name: William H Smith

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

MOTHER 14. Maiden name: Flint

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

16. (a) Informant's own signature: Billy Smith

(b) Address: Brookfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 9-1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Rose Hill Cem - Brookfield

18. (a) Signature of funeral director: Hill Chapel

(b) Address: Brookfield 445

19. (a) 5/8/40 (Date received local registrar) (b) Mont Lucas (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7 year 1940 hour 8:30 minute a M.

21. I hereby certify that I attended the deceased from May - 7 -, 1940, to May - 7 -, 1940 that I last saw him alive on May - 7 -, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Apoplexy	6 hrs
Due to: Arteria Sclerosis	yrs
Other conditions (Include pregnancy within 3 months of death): —	
Major findings: Of operations —	
Of autopsy —	

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? (Specify type of place) —

While at work? — (e) Means of injury: —

23. Signature: Mont Lucas M.D. (M. D. or other)

Address: Brookfield Mo Date signed: 5-8-40

(Licensed Embalmer's Statement on Reverse Side)

WHITE PAPER—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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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 J. H. Blacklock, Registered Apprentice No. ..... working under my personal supervision.

Signed J. H. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield Ma

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.