

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18820**

FILED JUN 22 1940
Registration District No. **4266**

Primary Registration District No. **8508 4266** Registrar's No. **10**

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Conway Mo
(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) 2
(d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days)

In this community _____
years, months or days)
3. (a) PRINTE FULL NAME Leslie L. Smith 530
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 single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased. Nov 22 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 5 23 hr. min.

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

10. Usual occupation stock trader

11. Industry or business _____

FATHER { 12. Name James W Smith
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name Sarah Jane Smith
15. Birthplace Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bell Pease
(b) Address Conway Mo

17. (a) Burial (b) Date thereof 5/18/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bildreuth Cem

18. (a) Signature of funeral director W. E. Halverson
(b) Address Halverson Mo

19. (a) 6-10-40 (b) Arac Montgomery
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede
(c) City or town Conway Mo
(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 May day 15
year 1940 hour 80 minute P M.

21. I hereby certify that I attended the deceased from April 15, 1940, to May 15, 1940
that I last saw him alive on May 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis - myocardial degeneration
Due to _____

Due to _____
Other conditions (include pregnancy within 3 months of death) 42C

Major findings: Of operations _____
Of autopsy _____

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? 42C

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

23. Signature W. E. Halverson (M. D. or other) Mo
Address Halverson Date signed 5-22-40

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.

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 Myself

....., Registered Apprentice No.....
working under my personal supervision.

Signed W.E. Holman

Licensed Embalmer No. 4107

P. O. Address Lebanon, N.

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.