

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

HEAD MUL 27 1940

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

22351  
Do not use this space.

1. PLACE OF DEATH  
 (a) County New Madrid Registration District No. 274  
 (b) Township Clinton Primary Registration District No. 4063  
 (c) City Helbourn (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James E. Smith  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-6-88

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hra. or .....min.
	<u>52</u>	<u>1</u>	<u>18</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. merchant  
 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) Jan - 40  
 11. Total time (years) spent in this occupation 64

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) VS

FATHER  
 13. NAME Charles Smith  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

MOTHER  
 15. MAIDEN NAME Margorie Hatch  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

17. INFORMANT (ADDRESS) Charles Smith  
Helbourn

18. BURIAL, CREMATION, OR REMOVAL PLACE Helbourn DATE 6-26 1940

19. FUNERAL DIRECTOR (ADDRESS) Helbourn  
Helbourn

20. FILED 6-25 1940 E. E. Jones  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-24 1940

22. I HEREBY CERTIFY, That I attended deceased from June 15 1940 to June 24 1940  
 Last saw hus. alive on June 24 1940. Death is said to have occurred on the date stated above, at 4503.  
 The principal cause of death and related causes of importance were as follows:  
Pulmonary tuberculosis  
 Date of onset 1938

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_ (Signed) Clark M. Fann M. D.  
 (Address) Helbourn Mo

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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RECEIVED

District Health Officer No. 2

District File Number 740-124

Date Filed 7/17/40

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No. ....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by .....

..... L. E. ....

No. .... or by ....., Registered Apprentice No. ....

working under my personal supervision.

Signed .....

Licensed Embalmer No. ....

**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.)**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22357

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 274

Primary Registration District No. 4063

Registrar's No.

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

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Rolla  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

James E. Smith Jr.

(b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_

(Month) (Day) (Year)

8. AGE:

Years 52 Months 1 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

New Madrid, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_

(Burial, cremation, or removal)

(b) Date thereof \_\_\_\_\_

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 6-25-40

(Date received local registrar)

(b) \_\_\_\_\_

E. E. Jones  
(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 24  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ 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 \_\_\_\_\_

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 Clayton McRaven (M. D. or other) \_\_\_\_\_  
Address Marston Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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