

FILED JUL 12 1940

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

22724
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Francois Registration District No. 779
 (b) Township St. Francois Primary Registration District No. 624A
 (c) City Osceola, Mo. (d) Street No. _____
 (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 30 Mrs. Stella Martha Smith
 (a) Residence, No. Osceola, Mo. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 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 Mr. Elbert M. Smith

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 6 - 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
43 8 1

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

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Co. Missouri
 13. NAME Mr. Robert Lee Beckwith
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Co. Missouri

MOTHER
 15. MAIDEN NAME Anne A. Ginkston Beckwith
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Co. Missouri

17. INFORMANT (ADDRESS) Mr. Elbert M. Smith, Osceola, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Three Rivers Cemetery DATE June 9, 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin W. Hood, Flat River, Mo.
 20. FILED 7-9-1940 W. P. Deekworth Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/7 1940

22. I HEREBY CERTIFY, That I attended deceased from April 2, 1940, to 6-7, 1940.
 I last saw h. alive on May 5, 1940. Death is said to have occurred on the date stated above, at 4 A. M.
 The principal cause of death and related causes of importance were as follows:
Rheumatic Heart disease Date of onset 45 A 2

Other contributory causes of importance:
decompensation
hypertension

Name of operation none Date of _____
 What test confirmed diagnosis? Exam Was there an autopsy? NO

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? no
 If so, specify _____ (Signed) O. H. Appleberry M. D.
 (Address) Flat River, 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.

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 Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address Flat River, Mo.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22724**

Registration District No. **779**

Primary Registration District No. **6024A**

Registrar's No. _____

1. PLACE OF BIRTH:

(a) County **St. Francois**
(b) City or town **Randolph T. P.**
(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 _____
years, months or days)

3. (a) **Full name** **Mrs Stella Martha Smith**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **43** Months **8** Days **1** If less than one day _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **7-9-40** (b) **W.P. Luckworth**
(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.

20. DATE OF DEATH: Month **6** day **7**
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?
_____ (Specify type of place)

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

23. Signature **C.H. Appleberry** M.D. or other) _____

Address **Flat River** Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-22724