

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.

FILED JUL 15 1940

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1. PLACE OF DEATH:

(a) County Saline  
 (b) City or town marshall  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Putnam Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 hr +  
 (Specify whether  
 In this community Life  
 years, months or days)

3. (a) PRINT FULL NAME Sandra Sue SMITH-530

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Fe 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 June 6 - 1940  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 4 hr. \_\_\_\_\_ min.

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

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

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

12. Name John Walter Smith

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

14. Maiden name Bertha Mae Floyd

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

16. (a) Informant's own signature John W. Smith

(b) Address myuni Mo

17. (a) Burial (b) Date thereof June 8 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miami Cem.

18. (a) Signature of funeral director Harry Heraberg

(b) Address marshall Mo

19. (a) 6-7-40 (b) Mary Kent  
 (Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline  
 (c) City or town marshall  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Putnam Hospital  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7  
 year 1940 hour 3:50 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from Birth  
June 6 - 1940, to June 7 1940  
 that I last saw her alive on June 7 - 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth Duration \_\_\_\_\_  
Born at 7 mo gestation

Due to Don't know

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 15A

Major findings: Of operations None

Of autopsy None

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?  
No  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. Putnam (M. D. or other) \_\_\_\_\_  
 Address marshall Mo Date signed 6-7-40

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 7-11-40

**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

*Felix Benz*

Licensed Embalmer No.

*H127*

P. O. Address

*Marshall*

**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.**