

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.

Registration District No. 15

Primary Registration District No. 3038

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 8 da  
 In this community 9 yr (Specify whether years, months or days)

3. (a) PRINT FULL NAME BEVLAH MAE SMITH

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

4. Sex Fe 5. Color or race W  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife John Walter Smith  
 6. (c) Age of husband or wife if alive 34 years  
 7. Birth date of deceased Sept 21 - 1911  
 (Month) (Day) (Year)

8. AGE: Years 28 Months 8 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

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

MOTHER FATHER  
 12. Name Lucian Floyd  
 18. Birthplace Stoughton (City, town, or county) Mo (State or foreign country)  
 14. Maiden name Alice West  
 15. Birthplace Stoughton (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature John W. Smith  
 (b) Address Marshall Mo  
 17. (a) Burial (b) Date thereof June 16 - 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Miami Mo

18. (a) Signature of funeral director Harry Hershberger  
 (b) Address Marshall Mo  
 19. (a) 6-15-40 (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 Miami Rural  
 (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 June day 13  
 year 1940 hour 9:25 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from June 13 1940, to June 13 1940, that I last saw h<sup>e</sup> alive on June 13 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Pelvic abscess following ruptured tube R.  
 Due to \_\_\_\_\_ Duration 4 wks

Due to Pregnancy - Delivered June 6 - 1940  
 Other conditions 147  
 (Include pregnancy within 3 months of death)

Major findings: abscess, multiple  
 Of operations Existed at time of delivery  
 Of autopsy None  
 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? \_\_\_\_\_

23. Signature A. Putnam (M. D. or other) \_\_\_\_\_  
 Address Marshall Mo Date signed 6-14-40  
 (Specify type of place) \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
 While at work? \_\_\_\_\_

RECEIVED  
District Health Officer No. 8,  
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, 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.