X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 16 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25595

Registration District No. 470

Primary Registration District No. 3633

Registrar's No. 812

1. PLACE OF DEATH:

(a) County Lawrence

(b) ~~City or town~~ Mount Vernon Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri State Sanatorium 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 123 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton

(c) City or town Neosho
(If outside city or town limits write "RURAL")

(d) Street No. 313 West Brook
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Stonie Smith 530

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Fannie Patterson Smith

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased February (Month) 25th (Day) 1886 (Year)

8. AGE: Years 54 Months 4 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Fayetteville (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation Granite Cutter

11. Industry or business Monument

FATHER
12. Name Daniel A. SMith
13. Birthplace Fayetteville (City, town, or county) Arkansas (State or foreign country)

MOTHER
14. Maiden name Nancy Strickler
15. Birthplace Unknown (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk
(b) Address Missouri State Sanatorium

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-40 (Month) (Day) (Year)
(c) Place: burial or cremation Neosho Mo

18. (a) Signature of funeral director Carley Thompson
(b) Address Neosho Mo

19. (a) 7-22-40 (Date received local registrar) (b) P. A. HOLMES (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 22 day _____ year 1940 hour 2:40 minute P M.

21. I hereby certify that I attended the deceased from March 22d, 1940 to July 22d, 1940; that I last saw him alive on July 22d, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Acute anoxemia — Duration Eleven Months

Due to Silico-Tuberculosis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Same

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

23. Signature D. L. Coffman (M. D. or other) M.D.
Address Mt Vernon Mo Date signed 7-22-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number 840-2496
Date Filed AUG 08 1940

AUG 08 1940

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 Carley T. Thompson

Licensed Embalmer No. 3259

P. O. Address Neosho Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25-395

Registration District No. 470 Primary Registration District No. 5633 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Mt Vernon 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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME Stonie Smith
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 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 54 Months 4 Days 27 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22 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.

	Duration
Immediate cause of death Acute anoxemia	
Due to Tuberculosis (Pulmonary)	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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

23. Signature D. L. Coffman (M. D. or other)
Address Mt Vernon Date signed