

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27873

State File No. _____

Registration District No. 50

Primary Registration District No. 3004

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Butler
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
313 Havana Street 2
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bates

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

(d) Street No. 313 Havana St
(If rural, give location)

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

3. (a) PRINT FULL NAME Elizabeth Smith 536

3. (b) If veteran, name war no

3. (c) Social Security No. no

20. DATE OF DEATH: Month Aug day 16th
year 1940 hour 2:00 minute _____ M.

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife Frank Smith

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

7. Birth date of deceased: July 3, 1859
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 10th = 40 to Aug 16th, 40 that I last saw her alive on Aug 16 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

<u>81</u>	<u>1</u>	<u>13</u>	hr. _____ min. _____
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Immediate cause of death Cerebral hemorrhage

Due to Chronic nephritis

Due to _____

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

Other conditions 171
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Harvey P. Robinson

13. Birthplace not know 9
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Rand

15. Birthplace not known 9
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Pearle Smith

(b) Address Butler Mo

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

(c) Place: burial or cremation Oak Hill

18. (a) Signature of funeral director Culver

(b) Address Butler Mo

19. (a) Aug 17 1940 (b) Nina Culver
(Date received local registrar) (Registrar's signature)

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? 53

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

23. Signature A. D. Lathin (M. D. or other) MD

Address Butler Mo Date signed 8-16-40

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

RECEIVED

District Health Officer No. 7,
District File Number 9-40-1337
Date Filed 9-13-40

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 R. Hinton Lisk

Licensed Embalmer No. 4123

P. O. Address Butler, Pa

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, fact should be so stated above.