

LED SEP 19 1940

Registration District No. 34

Primary Registration District No. 4197

Registrar's No. 57

1. PLACE OF DEATH:  
(a) County Harrison  
(b) City or town Bethany  
(c) Name of hospital or institution: Bethany Hospital  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Gentry  
(c) City or town \_\_\_\_\_  
(d) Street No. Denver  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Essie Ben Smith  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 14 year 1940 hour 15 minute 30 A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced divorced  
6. (b) Name of husband or wife Dale Smith 6. (c) Age of husband or wife if alive 31 years  
7. Birth date of deceased: Mary 30 1909  
(Month) (Day) (Year)

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death Car accident! Duration \_\_\_\_\_

8. AGE: Years 31 Months 2 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Badly injured  
Due to in head Head concussion

9. Birthplace Worth Co MO  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Waitress  
11. Industry or business \_\_\_\_\_  
12. Name William McNeese  
13. Birthplace Tenn  
14. Maiden name Bettie Barnes  
15. Birthplace MO

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Clara Smith  
(b) Address Denver MO  
17. (a) Buried (b) Date thereof Aug 15 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Triller Cemetery  
18. (a) Signature of funeral director Clifford Brooks  
(b) Address \_\_\_\_\_  
19. (a) 8-14-40 (b) ad Wessling  
(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) accident  
(b) Date of occurrence Aug 13<sup>th</sup>  
(c) Where did injury occur? On Highway 4 + 69 South  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 300  
(Specify type of place) \_\_\_\_\_  
While at work (e) Means of injury \_\_\_\_\_  
23. Signature Joe E. Wheeler Coroner  
Address Bethany MO Date signed Aug 14

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

MOTHER, FATHER

219 M  
98

RECEIVED

District Health Officer No. 11;

District File Number 941-1345

Date Filed SEP 9 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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28604

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 334

Primary Registration District No. 4197

Registrar's No. 57

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

1. PLACE OF DEATH:

(a) County Harrison  
(b) City or town Bethany  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

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 Essie Fern Smith

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced Div

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 31 Months 2 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Aug day 14  
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 Car accident Duration \_\_\_\_\_

Badly injured in  
Due to head  
head concussion

Due to Collision with Road Object

Other conditions Car crash against telephone pole  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 2/10/40

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?  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Joe E. Wheeler (M. D. or other)  
Address Bethany Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

