

FILED SEP 25 1940

State File No. \_\_\_\_\_

Registration District No. 546

Primary Registration District No. 5735

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
Phelps County, Missouri  
(a) County Phelps  
(b) City or town St. James, Missouri  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
In this community None  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
Missouri  
(a) State Missouri (b) County Phelps  
St James,  
(c) City or town St James,  
(If outside city or town limits, write "RURAL")  
(d) Street No. none  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? No years.

3. (a) PRINT FULL NAME Donas & Smallwood. 543

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married, wife

6. (b) Name of husband or wife Angie E. Smallwood. 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased. Sept, 7th, (Month) (Day) (Year) 1864

8. AGE: Years 74 Months 11 Days 18 If less than one day hr. min.

9. Birthplace Cincinnati, Ohio. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming.

12. Name Not Known

13. Birthplace " (City, town, or county) (State or foreign country)

14. Maiden name Not Known. (City, town, or county) (State or foreign country)

15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant D. Smallwood

(b) Address Bland, Mo.

17. (a) P. Jones (b) Date thereof Sept 1-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Maponi Cemetery

18. (a) Signature of funeral director Jones & Leonard

(b) Address P. Jones, Mo. HES

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August, day 25th, year 1940 hour 1 p.m minute 0 M.

21. I hereby certify that I attended the deceased from Aug 25 1940 to same date 1940 that I last saw him alive on head 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy

Due to arteriosclerosis

Due to "

Other conditions (include pregnancy within 3 months of death) 80.0

Major findings: Of operations " Of autopsy "

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? " (Specify type of place) (e) Means of injury "

23. Signature J. H. ... Date signed "

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 940 924

Date Filed \_\_\_\_\_

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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 \_\_\_\_\_

Harry Jonas.

#2628

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Harry Jonas

#2628

Licensed Embalmer No. \_\_\_\_\_

P. O. Address Steensville

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29088  
Registrar's No. 15

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 546

Primary Registration District No. 5735

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

1. PLACE OF DEATH:

(a) County Maries  
(b) City or town Johnson T. P.  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Donas Smalwood

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 74 Months 11 Days 18 If less than one day \_\_\_\_\_ 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)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) Oct-18-1940 (b) Sam a. Warner  
(Date received local registrar) (Registrar's signature)

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.

20. MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Aug day 25 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 \_\_\_\_\_

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

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature J. B. Underwood (M. D. or other) \_\_\_\_\_

Address High Gate Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

