

Registration District No. 82

Primary Registration District No. 4523

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(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) 2
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 16 years, months or days

3. (a) PRINT FULL NAME Columbus Smith 530

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

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

6. (b) Name of husband or wife Mary Smith 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Feb. 12 1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 4 Days 27 If less than one day hr. min.

9. Birthplace Coma Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Columbus Smith

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

14. Maiden name COYA UNKNOWN

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Smith

(b) Address Sikeston, Mo. Gen Del.

17. (a) Burial (b) Date thereof 7/10/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director John Cleaver
(b) Address Sikeston, Mo.

19. (a) 8-6-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) Missouri (b) County Scott
(c) City or town Sikeston, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Sunset Addition
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1940 hour 2 minute P.M.

21. I hereby certify that I attended the deceased from 7-2-40 1940 to 7-9-40 1940
that I last saw him alive on July 9 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Pulmonary Tuberculosis - 10 yrs.
Duration _____

Due to _____

Due to _____

Other conditions 23
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none

(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? _____

(e) Means of injury _____
(Specify type of place) (e) Means of injury

23. Signature M. Anderson (M. D. or other) _____
Address Sikeston Date signed 9-11-40

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. 2

District File Number 840-131

Date Filed 8/7/40

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 me

embalmer, Registered Apprentice No. _____
working under my personal supervision.

Signed John A. Green

Licensed Embalmer No. 2941

P. O. Address Seaton

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.