

No. 40
17-39
X23159

OCT 10 1940

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 253

2224
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: CALLAWAY
 (a) County CALLAWAY
 (b) City or town FULTON
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: CALLAWAY HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution THR. 40 MIN.
 (Specify whether
 In this community _____
 years, months or days) 1

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County CALLAWAY
 (c) City or town RURAL
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1 Mi. WEST OF TELBETS
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME ANNA MAE SMITH
 3. (b) If veteran, name war 0
 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race White
 6. (a) Single, widowed, married, divorced SINGLE
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased July 11 1923
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
17 2 17 hr. min.
 9. Birthplace TELBETS MISSOURI
 (City, town, or county) (State or foreign country)

10. Usual occupation SCHOOL GIRL
 11. Industry or business _____
 12. Name JAKE SMITH
 13. Birthplace TELBETS MISSOURI
 (City, town, or county) (State or foreign country)
 14. Maiden name ANNA SHELTON
 15. Birthplace TELBETS MISSOURI
 (City, town, or county) (State or foreign country)

16. (a) Informant JAKE SMITH
 (b) Address TELBETS, MISSOURI
 17. (a) BURIAL (b) Date thereof OCT 15 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation RIVER-VIEW TELBETS
 18. (a) Signature of funeral director Glen Y. Maupin
 (b) Address 700 East Fulton, MO 101
 19. (a) Sept 30, 1940 (b) R. N. Crewe
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept day 29
 year 1940 hour 2 minute 50 a.m.
 21. I hereby certify that I attended the deceased from on Sept 29-1940 for about 40 minutes previous to about 11:50 that I last saw her alive on Sept 29, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage to injury within the skull
 Due to Fracture of skull

Due to Automobile accident
 Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
 Major findings: Of operations
 Of autopsy _____
 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) Accident
 (b) Date of occurrence Sept. 29-1940
 (c) Where did injury occur? No. 54 U.S. Highway, Fulton, Callaway Co., MO
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, or industrial place, or public place? No. U.S. Highway 200 St. Fulton MO
 While at work? No (Specify type of place) (e) Means of injury Automobile
 23. Signature R. N. Crewe (M. D. or other) _____
 Address Fulton 2940 Date signed 9/30/40

210 m
90

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 Gen. G. Mays
Licensed Embalmer No. 2725
P. O. Address Fulton, Mo.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3155-2

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. _____

1. PLACE OF DEATH

(a) County Callaway
(b) City or town Fulton
(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 _____
In this community _____ (Specify whether
years, months or days) i _____

3. (a) PRINT FULL NAME Anna Mal Smith

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

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

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 Months Days If less than one day
17 2 17 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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) _____ (b) _____ (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. DATE OF DEATH: Month Sept day 29
year 1946 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: hemorrhage and injury to skull

fracture of skull in automobile accident. Car collided with the abutment of a bridge over a creek.

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) (e) Means of injury _____

23. Signature W. H. Crews (M. D. or other) _____

Address _____ Date signed 11/18/40

SUPPLEMENTAL

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

