

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 32243Registration District No. 170Primary Registration District No. 3020Registrar's No. 170

## 1. PLACE OF DEATH:

(a) County Jasper  
 (b) City or town Carthage  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Home - 110 N. Garrison  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2  
 (Specify whether  
 In this community 2 years  
 years, months or days)

3. (a) PRINT  
FULL NAME Ora Smith3. (b) If veteran,  
name war ✓3. (c) Social Security  
No. 491-07-91684. Sex M5. Color or  
race N.6. (a) Single, widowed, married,  
divorced married6. (b) Name of husband or wife  
Aroma Smith6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased May 11 1909  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

3141

hr. min.

9. Birthplace Sarepie  
(City, town, or county)Mo.  
(State or foreign country)10. Usual occupation Laborer11. Industry or business (W.P.A. Baid)12. Name Albert SmithSarepieMo.13. Birthplace Sarepie  
(City, town, or county)Mo.  
(State or foreign country)14. Maiden name Fay PattersonSarepieMo.  
(State or foreign country)15. Birthplace Sarepie  
(City, town, or county)Mo.  
(State or foreign country)16. (a) Informant's own signature Aroma Smith(b) Address Sarepie Mo.17. (a) Burial(b) Date thereof 9-7-40  
(Month) (Day) (Year)(c) Place: burial or cremation Sarepie Cemetery18. (a) Signature of funeral director Roland C. Englage(b) Address Sarepie Mo.19. (a) Sept 6, 1940(b) W. J. McEntire, M.D.

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
 (c) City or town Carthage  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 110 N. Garrison  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5  
year 1940 hour 10 minute 50 P. M.21. I hereby certify that I attended the deceased from June 1st  
1940 to Sept. 5th 1940  
that I last saw him alive on 9/5  
and that death occurred on the date and hour stated above. 1940

Immediate cause of death

Pulmonary Tuberculosis 2 yrs.

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

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

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

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

Duration

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?  
at home  
 (Specify type of place)  
 (e) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. J. McEntire (M. D. or other) 11/10  
Address Carthage Mo. Date signed 9/6/40

**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.....

Licensed Embalmer No. 946

P. O. Address. Mr. Vernon T.

**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.**