

NOV 15 1940 89
Registration District No.

Primary Registration District No. 3007

State File No.
Registrar's No. 311

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Poplar Bluff Hospital
(If not in hospital or institution, write street number or location) 3
(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Fred Greene Smith

8. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

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

6. (b) Name of husband or wife Pearl 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. Feb. 10 1889
(Month) (Day) (Year)

8. AGE: Years 51 Months 7 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Bookkeeper

11. Industry or business unknown

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Fred Smith
(b) Address Dexter, Mo.

17. (a) Burial (b) Date thereof 10/6/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blytheville, Ark.
Blankenship-Strickland

18. (a) Signature of funeral director Dexter, Mo.
(b) Address

19. (a) 10-7-40 (b) Blattlinger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard
(c) City or town Dexter
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5th
year 1940 hour 12 minute 45 P. M.

21. I hereby certify that I attended the deceased from Sept 29 1940 to Oct 5 1940
that I last saw him alive on Oct 5 1940
and that death occurred on the date and hour stated above.

Immediate cause of death:
uremia 7 days
nephritis 7
hypertension 7

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 [Signature] (M. D. or other) _____
Address Poplar Bluff, Mo. Date signed 10/7/40

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

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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, *df* by _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. **3479**

P. O. Address **Dexter, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34903**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **89**

Primary Registration District No. **3007**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Butler**
(b) City or town **Caplan Bluff**
(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)

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 **Fred Green Smith**

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 **51** Months **7** Days **25** If less than one day 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 _____

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) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Oct** day **5** 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 _____ and that death occurred on the date and hour stated above. Underline the cause of death **uremia**

Due to **Chronic Nephritis**
Due to **Hypertension**

Other conditions (Include pregnancy within 3 months of death) **12/1**

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. B. Mebert** (M. D. or other) _____ Address _____ Date signed _____

Duration **?**
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

