

STANDARD CERTIFICATE OF DEATH

State File No. 11

Registration District No. 461

Primary Registration District No. 5625

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Rural - Lexington Township.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1 Mi. South Lexington, Mo
(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 Macilda Frances Smith

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

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

7. Birth date of deceased Oct 1 1953
(Month) (Day) (Year)

8. AGE: Years 87 Months 0 Days 25 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife - Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Morrison

18. Birthplace Unknown Va.
(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 Sam Smith
 (b) Address Lexington, Mo.

17. (a) Burial (b) Date thereof 10-28-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Odessa Cem.

18. (a) Signature of funeral director Bliven & Sons
 (b) Address Odessa Mo.

19. (a) Oct 28/40 (b) Delia T. Bates
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
 (c) City or town Odessa Mo.
(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 25
 year 1940 hour 3:00 minute _____ a.m.

21. I hereby certify that I attended the deceased from Sept. 2
 _____, 1940 to Oct. 25, 1940
 that I last saw him alive on Oct. 24, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Mycocarditis Chronic
Eggs of cardiac Chorio

Due to fractured hip

Due to Smoking

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? _____

8:00 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____

28. Signature E. B. Libbert (M. D. _____)
 Address Odessa Mo. Date signed 10/27/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1442
96
99

RECEIVED
District Health Officer No. 8,
District File Number 11-12-40
Date Filed

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 Ben C. Blum

Licensed Embalmer No. 1836

P. O. Address Adena, Md.

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. **35-684**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **461**

Primary Registration District No. **5625**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Lafayette**

(b) City or town **Wilmington T.P.**
(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 _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME **Macilda Frances 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 **wid**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year) _____

8. AGE: Years **87** Months **0** 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 _____

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) _____ (b) _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Oct** day **26** 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 **myocarditis chr**

Chr. Endocarditis

Due to **heart tip**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **92W**

Major findings: Of operations _____

Of autopsy _____

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) **accident**

(b) Date of occurrence **Don't know**

(c) Where did injury occur? **in home** (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 **Edna Laber** (M. D. or other) _____
Address **Olinda mo** Date signed _____

SUPPLEMENTAL

