

FILED NOV 25 1940

Registration District No. 345 Primary Registration District No. 580-0 Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:  
 (a) County New Madrid  
 (b) City or town Big Prairie  
(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 Lifetime  
years, months or days

3. (a) PRINT FULL NAME Arline Smith  
 3. (b) If veteran, name war Infant  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Infant  
 6. (b) Name of husband or wife Infant  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased June 22 1940  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	2	27	hr. _____ min.

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

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Aron Smith  
 13. Birthplace Mississippi Co. Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Pauline Harr  
 15. Birthplace Mississippi Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Aron Smith  
 (b) Address Matthews, Mo.

17. (a) Burial (b) Date thereof 9/21/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Logwood Missouri

18. (a) Signature of funeral director [Signature]  
 (b) Address Jikeston, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County New Madrid  
 (c) City or town Matthews, Missouri  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
Rural  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19  
 year 1940 hour 5 minute \_\_\_\_\_ P.M.  
 21. I hereby certify that I attended the deceased from Sept 16-  
140 to Sept 19 1940  
 that I last saw h<sup>er</sup> alive on Sept 18 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer  
 Duration \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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) \_\_\_\_\_  
 (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? \_\_\_\_\_

23. Signature George W. Whitaker (M. D. certificate) \_\_\_\_\_  
(Specify type of place) (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 Address East Prairie Mo Date signed 9/24/40

RECEIVED

District Health Officer No. 2

District File Number 1140-166

Date Filed 11/7/40

MAR 15 1951

MAR 17 1951

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

*Lawrence J. Johnson*

Licensed Embalmer No. 3704

P. O. Address Sikeston, Missouri

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 35902

Registration District No. 343

Primary Registration District No. 5800

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County New Madrid  
(b) City or town Big Prairie  
(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)

3. (a) PRINT FULL NAME Arline 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 mf  
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  
2 27 \_\_\_\_\_ 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 (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation

18. (a) Signature of funeral director  
(b) Address  
19. (a) Jan 10 1941 (b) Mildred Deane  
(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 Sept day 19  
year \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
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 Geo. Whitaker (Name or other)  
Address East prairie Mo \_\_\_\_\_

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

SUPPLEMENTAL

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

5. 1. 1971

1. 1. 1971

2.

1. 1. 1971

2.

1. 1. 1971

1. 1. 1971