

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35903

State File No. _____

Registration District No. 345 Primary Registration District No. 582 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County New Madrid
 (b) City or town Matthews, Missouri Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Big Prairie Township
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20
(Specify whether)
 In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County New Madrid
 (c) City or town Matthews, Missouri Rural
(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 Aline Smith
 3. (b) If veteran, name war Infant
 3. (c) Social Security No. Infant
 4. Sex F 5. Color or race W
 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)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept. day 20
 year 1940 hour 11 minute 00 A. M.
 21. I hereby certify that I attended the deceased from Sept 16
1940, to Sept 20, 1940
 that I last saw h. or alive on Sept 18, 1940
 and that death occurred on the date and hour stated above.

8. AGE: Years 0 Months 2 Days 28
 If less than one day _____ hr. _____ min.

Immediate cause of death Colitis
 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.

9. Birthplace New Madrid County, Missouri
(City, town, or county) (State or foreign country)
 10. Usual occupation Infant
 11. Industry or business _____
 MOTHER FATHER { 12. Name Aron Smith
 13. Birthplace Mississippi County, Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Pauline Barr
 15. Birthplace Mississippi County, Missouri
(City, town, or county) (State or foreign country)
 16. (a) Informant Aron Smith
 (b) Address Matthews, Missouri
 17. (a) Burial (b) Date thereof 9/21/40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Dogwood Cemetery, Big Prairie, Mo.
 18. (a) Signature of funeral director [Signature]
 (b) Address Sikeston, Missouri
 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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? _____
 (e) While at work? _____ (Specify type of place)
 (f) Means of injury _____
 23. Signature George W. Whitaker (M. D. or other) _____
 Address Big Prairie Mo Date signed 9/24/40

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

RECEIVED

District Health Officer No. 2,

District File Number 1140-160

Date Filed 11/7/40

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 *Harvey 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

State File No. 35903

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 345

Primary Registration District No. 5800

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 Boonville
(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

Aline Smith

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced inf

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

Months

Days

If less than one day

2

28

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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____

Jan 10 1946 (b) _____

Mildred Seane
(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 20
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 _____

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? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature Geo. W. Whitaker (M. D. or other) _____

Address East Princess _____

SUPPLEMENTAL

