

FILED APR 15 1941

Registration District No. 249

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5347

State File No. 10527

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Waverly
(b) City or town Gilman City, Mo Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: L. A. Smith Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Waverly
(c) City or town Gilman City, Mo 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. 0 years.

3. (a) PRINT FULL NAME ALEXANDER SMITH

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Abbie Smith 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Nov 24 1877
(Month) (Day) (Year)

8. AGE: Years 69 Months 1 Days 12 If less than one day hr. _____ min. _____

9. Birthplace Harrison, Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Sylvester Smith
13. Birthplace W. Va. Indiana (City, town, or county) (State or foreign country) 1
14. Maiden name Mary Jane Payne
15. Birthplace Waverly, Mo (City, town, or county) (State or foreign country) 0

16. (a) Informant Mrs Abbie Smith
(b) Address Gilman City, Mo Rural

17. (a) Burial (b) Date thereof Jan 9 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Gilman Cemetery

18. (a) Signature of funeral director W. D. Hanks
(b) Address Gilman City, Mo

19. (a) March 7, 1941 (b) Mrs H. A. Cunningham
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 7
year 41 hour 8 minute 40 A.M.

21. I hereby certify that I attended the deceased from Oct - 27
1940 to JAN - 7 - 1941
that I last saw him alive on JAN - 7 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Nephritis Duration 2 Mo

Due to Metastasis of liver
Due to (Secondary) Chronic Myocarditis
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) (Country) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
226 (Specify type of place) (e) Means of injury 22
While at work? _____

23. Signature J. C. WALKER (M.D. or other) DO
Address GILMAN CITY MO Date signed Mar 31

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

92A

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 _____

W D Haines

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed *W D Haines*

Licensed Embalmer No. *949*

P. O. Address *Gilman City, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 10227

Registration District No. 249

Primary Registration District No. 5347

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Darwin
 (b) City or town Worth 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 _____
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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Alexander Smith
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 1 day 7
 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 _____

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 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
69 1 14 _____ 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 (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) _____ (b) Date thereof (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) March 7, 1941 (b) Mrs. A. H. Cunningham
(Date received local registrar) (Registrar's signature)

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? _____

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

23. Signature J. C. Walker (M. D. or other)

Address Gilman City _____

SUPPLEMENTARY

MOTHER FATHER

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10527

Registration District No. 249

Primary Registration District No. 2347

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dairies
(b) City or town Wash Twp
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Alexander 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 _____

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 69 Months 1 Days 14 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 _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

(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) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 7 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis Duration _____

Metastasis of lung

Due to secondary

Chronic myocarditis

Due to this follow Chronic

Nephritis

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? _____

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

23. Signature J.C. WALKER (M.D. or other) MD

Address FILMAN City MO Date signed JUNE 10 1947

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

MOTHER FATHER

SUPPLEMENTARY