

Registration District No. **318**

Primary Registration District No. **2001**

Registrar's No. **249**

1. PLACE OF DEATH:  
(a) County **GREENE**  
(b) City or town **Springfield**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. John's Hospital**  
(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 **Steven Hiram Smith**

3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **702-07-5958**

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

6. (b) Name of husband or wife **Jessie Smith** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **December 27, 1884**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>56</b>	<b>2</b>	<b>28</b>	hr. min.

9. Birthplace **Richmond, Virginia**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Stationary Engineer**

11. Industry or business **Railroad Shops**

12. Name **Chester B. Smith**

13. Birthplace **Unknown / Virginia**  
(City, town, or county) (State or foreign country)

14. Maiden name **Malissa Pettit**

15. Birthplace **Unknown / Virginia**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Jessie Smith**

(b) Address **Springfield, Missouri**

17. (a) **Burial** (b) Date thereof **3/29/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Park Cemetery**

18. (a) Signature of funeral director **Alma Lohmeyer Funeral Home**

(b) Address **Springfield, Missouri**

19. (a) **3-28-41** (b) **W. E. Handley**  
(Date received local registrar) (M.D. or other) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Greene**  
(c) City or town **Springfield**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Route 9**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **25** year **1941** hour **6** minute **0** M.

21. I hereby certify that I attended the deceased from **March 21, 1941**, to **March 25, 1941**, that I last saw **her**, alive on **March 25, 1941**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebritis -**

Due to **Perforated caecum**

Due to \_\_\_\_\_  
Other conditions **✓**  
(Include pregnancy within 3 months of death)

Major findings: **✓**  
Of operations **✓** **Acute Cerebritis**  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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? **4814**  
(Specify type of place) (e) Means of injury **✓**

Signature **W. E. Handley** (M. D. or other) **W. E. Handley**  
Address **Med Arts Bldg** Date signed **March 29, 1941**

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

629

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121

**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

*Harlow Knalib*

Licensed Embalmer No. *4065*

P. O. Address

*Springfield, 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, fact should be so stated above.**

Registration District No. 318

Primary Registration District No. 2001

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

1. PLACE OF DEATH:

(a) County Dreage  
(b) City or town Springfield  
(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 Steven Hiram 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 \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 2 28 hr. min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State, 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 \_\_\_\_\_  
(Burial, cremation, or removal) (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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 25  
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 time stated above.

Immediate cause of death Peritonitis Duration \_\_\_\_\_

Due to Perforated Caecum

Due to unable to determine cause had been tested about 6 wks. at hospital by Dr. R. M. Taylor at Fair St. Hospital, Springfield, Mo. for bladder. (understand, within 3 months of death) appendix had been removed

Major findings: General Peritonitis PHYSICIAN \_\_\_\_\_  
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?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

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

1941

S-10711