

FILED APR 28 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

12317  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jesse Registration District No. 565  
 (b) Township Sherrill Primary Registration District No. 6149  
 (c) City \_\_\_\_\_ (d) Street No. 1 Registered No. 12  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME William H. Smith  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (or WIFE OF) Martha Smith  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 30, 1869  
 7. AGE YEARS 71 MONTHS 4 DAYS 22 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer  
 10. Date deceased last worked at this occupation (month and year) Mar 1941 11. Total time (years) spent in this occupation 51  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warren Co. Mo  
 FATHER  
 13. NAME Amandas Smith  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warren Co. Mo  
 MOTHER  
 15. MAIDEN NAME Eliza Combsage  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warren Co. Mo  
 17. INFORMANT (ADDRESS) Robert Smith  
Lebanon Mo  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Raylen DATE 3/23/41  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith & Ferguson  
Lebanon Mo  
 20. FILED 3/22 1941 515 Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/22/41  
 22. I HEREBY CERTIFY, That I attended deceased from 3-20, 1941, to 3-22, 1941  
 I last saw him alive on Mar 22, 1941 Death is said to have occurred on the date stated above, at 10:20 A.M.  
 The principal cause of death and related causes of importance were as follows:  
apoplexy  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
Fall a month before  
impacting head shoulder  
etc.  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Lebanon M. D.  
 (Address) Lebanon Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1562

AUG 4 1941

RECEIVED

District Health Officer No. 5,

District File Number 4415-30

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 Me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Hubert E. Ferguson

Licensed Embalmer No. 3945

P. O. Address Licking 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, above space should be left blank.

Registration District No. 868

Primary Registration District No. 6149

Registrar's No. 12

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

**1. PLACE OF DEATH:**

(a) County Texas

(b) City or town Sherrill  
(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 Wm H 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 W

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 71 Months 4 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 \_\_\_\_\_

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) 3/22/41 (b) [Signature] (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Texas

(c) City or town near Licking  
(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 3 day 22  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that 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 Leslie Randal (M. D. or other)  
Address Licking Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12317

Registration District No. 868

Primary Registration District No. 6149

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

1. PLACE OF DEATH:

- (a) County Wray
- (b) City or town Sherrill 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)

- 3. (a) PRINT FULL NAME Wm H. 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 W

- 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
	<u>71</u>	<u>4</u>	<u>22</u>	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)

- (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 3 day 22  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

- 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

- Immediate cause of death apoplexy Duration \_\_\_\_\_

- Due to \_\_\_\_\_

- Due to \_\_\_\_\_

- Other conditions Fall a month before  
(include pregnancy within 3 months of death)

- Major findings: Injuring head shoulders  
Of operation: of back

- 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 2-22-41

- (c) Where did injury occur? Back Street Wray Mo  
(City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
fell from wagon wheel

- While at work? yes (Specify type of place) (Means of injury) Fell from wagon wheel

- ? injury to neck, head & back

- 23. Signature [Signature] (M. D. or other) MD

- Address Wray Mo Date signed 2-24

SUPPLEMENTARY

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

MOTHER FATHER