DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 12 1941

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 14485

Registration District No. 309 — Primary Registration District No. 4183 — Registrar's No. 22

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

**1. PLACE OF DEATH:**

(a) County Gentry

(b) City or town Albany
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rose Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Gentry

(c) City or town Albany
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME William Henry 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 Married

6. (b) Name of husband or wife Lilly Ann McCall

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Oct. (Month) 6 (Day) 1874 (Year)

8. AGE: Years 66 | Months 6 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Ringgold Co. Iowa (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business ____

MOTHER FATHER

12. Name Thos. C. Smith

13. Birthplace Unknown (City, town, or county) Kentucky (State or foreign country)

14. Maiden name Mary Patrick

15. Birthplace Ringold, Iowa (City, town, or county) ____ (State or foreign country)

16. (a) Informant Clair Smith

(b) Address Fresno, California

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/41 (Month) (Day) (Year)

(c) Place: burial or cremation Grandview

18. (a) Signature of funeral director Lee Lloyd Brooks

(b) Address Albany Missouri

19. (a) MAY 2 1941 (Date received local registrar) W. T. Martin (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 30 year 1941 hour 12 minute 35 P.M.

21. I hereby certify that I attended the deceased from March — 15 —, 1941, to April 30, 1941; that I last saw h— alive on Apr. 30, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis — Duration 3 days.

Due to Arteriosclerosis

Due to Prostatism

Other conditions (Include pregnancy within 3 months of death) ____

Major findings: Of operations Prostatectomy April 29 — 1941

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? (Specify type of place)

(e) While at work? ____ (e) Means of injury ____

23. Signature Frank H. Rose (M.D. or other) M.D.

Address Albany, Mo. Date signed May 1-41.

(Licensed Embalmer's Statement on Reverse Side)

187

## 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 Clifford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany Ind

**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.**

S. No. 2B
0—4-25-41
I ×97852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 14483 -

Registration District No. 309 Primary Registration District No. 418 Registrar's No.

1. PLACE OF DEATH:
(a) County Dent
(b) City or town Salem
(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 Wm Henry Smith
3. (b) If veteran, name war (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 years

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

8. AGE: Years 66 | Months 6 | Days 24 | If less than one day 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
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) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 30
year 1941 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 Cerebral Thrombosis — Duration

Due to Arterio Sclerosis

Due to Prostatism Hypertrophy 1 2 W

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operation Prostatectomy

Of autopsy

PHYSICIAN
Underline the cause which 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?
(Specify type of place)
While at work? (e) Means of injury

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

S- 14485