DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 16 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25678

Registration District No. 119

Primary Registration District No. 5793a

Registrar's No. 15

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

1. PLACE OF DEATH:
(a) County Morgan
(b) City or town Rural Hawcreek Tw
(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 Missouri (b) County Morgan 71
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME DELLA ANN SMITH

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife W. T. Smith

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Dec. (Month) 5 (Day) 1885 (Year)

8. AGE: Years 55 Months 7 Days 3 If less than one day ..... hr. ..... min.

9. Birthplace Segrada (City, town, or county) 0 Missouri (State or foreign country)

10. Usual occupation house wife

11. Industry or business .....

FATHER
12. Name Tillman Wall
13. Birthplace ..... (City, town, or county) Indiana (State or foreign country)

MOTHER
14. Maiden name Melissa Christian
15. Birthplace Zora (City, town, or county) 0 Mo. (State or foreign country)

16. (a) Informant W. T. Smith
(b) Address Stover Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July (Month) 9 (Day) 1941 (Year)
(c) Place: burial or cremation Cable Ridge Cem.

18. (a) Signature of funeral director Rapp & Stevinson
(b) Address Stover Mo

19. (a) 8/11-41 (Date received local registrar) (b) Wm L Ripperger (Registrar's signature)

550

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8th year 1941 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from Dec ..... 1940, to July 8 ..... 1941; that I last saw her alive on July 8 ..... 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cancer of whole abdomen	1 yr
Due to	
Due to	
Other conditions ..... (Include pregnancy within 3 months of death)	

46

Major findings:
Of operations .....
Of autopsy No

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

23. Signature Chas A Hirst (M. D. or other) EMD
Address Stover Mo Date signed July 8 '41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 8-41-1314
Date Filed 8-13-41

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25678

Registration District No. 919 Primary Registration District No. 5793a Registrar's No.

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

1. PLACE OF DEATH:

(a) County Morgan

(b) City or town Rural
(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 Dellie A. Smith

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 Dec (Month) 5 (Day) 1885 (Year)

8. AGE: Years 55 Months 7 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1941 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 Carcinoma of Sigmoid

Due to

Due to

Other conditions 46e
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Chas A Hiest (M. D. or other)
Address Stover Date signed

SUPPLEMENTARY