S. No. 2
-11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29498

FILED SEP 11 1941

Registration District No. 96 Primary Registration District No. 6039 Registrar's No. 139

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

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Saline Co Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months (Specify whether years, months or days)
In this community About 60 yrs

2. USUAL RESIDENCE OF DEACEASED:
(a) State Mo. (b) County Saline
(c) City or town Marshall Rural
(If outside city or town limits write "RURAL")
(d) Street No. Saline Co. Home
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME SIM SMITH
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of ~~husband~~ or wife Rachel Barnes Smith
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 17 (Day) 1870 (Year)

8. AGE: Years 71 Months 8 Days 14 If less than one day hr. min.

9. Birthplace Saline Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farming
11. Industry or business Farming
MOTHER FATHER
12. Name Joseph Smith
13. Birthplace Unknown (City, town, or county) C (State or foreign country)
14. Maiden name Nancy Falls
15. Birthplace Unknown (City, town, or county) O (State or foreign country)
16. (a) Informant Hester Crosby
(b) Address Nelson Mo
17. (a) Nelson Mo (Burial, cremation, or removal) (b) Date thereof 9-2-41 (Month) (Day) (Year)
(c) Place: burial or cremation Nelson Mo
18. (a) Signature of funeral director F D Ferguson
(b) Address Marshall
19. (a) 9-1-41 (Date received local registrar) (b) Dep Mary Kent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 31 year 1941 hour 11:15 minute A.M.
21. I hereby certify that I attended the deceased from Aug 1, 1941, to Aug 31, 1941, that I last saw him alive on Aug 28, 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage & hemiplegia left	1 mo.
Due to: Hypertension	7
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? (Specify type of place)
While at work
(e) Means of injury

23. Signature [illegible] (M. D. ~~or other~~) (M.D.)
Address Marshall, Mo. Date signed 9-2-

(Licensed Embalmer's Statement on Reverse Side)

SEP 8 1941

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 F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Marshall

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, above space should be left blank.