

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.

Registration District No. 158

Primary Registration District No. 5223

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Cass
 (b) City or town Rural, Raymore, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 35 years
 years, months or days

3. (a) PRINT FULL NAME Sarah Malissa 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 Widowed
 6. (b) Name of husband or wife Charles Smith 6. (c) Age of husband or wife if alive ✓ years
 7. Birth date of deceased July 24, 1854
 (Month) (Day) (Year)

8. AGE: Years 87 Months 1 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace West Moreland Co., Pa.
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business ✓

MOTHER FATHER { 12. Name Blakely
 13. Birthplace unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Casaman
 15. Birthplace Pa.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Earl King

(b) Address RD # 2, Belton, Mo.

17. (a) Rural (b) Date thereof Sept 10, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Belton, Mo.

18. (a) Signature of funeral director B. N. Brown, Sons

(b) Address Belton, Mo.

19. (a) 9-11-41 (b) R. M. Miller
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass 10
 (c) City or town Rural Raymore 0
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. S.E. 0
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 8
 year 1941 hour 6:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from August 27
 1941 to September 8, 1941;
 that I last saw her alive on September 8, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Relator Heart Duration 1 day
 Due to Chronic Myocarditis

Due to _____
 Other conditions fracture right femur ✓ 3 weeks
 (Include pregnancy within 3 months of death)

Major findings: _____ PHYSICIAN _____
 Of operations _____
 Of autopsy _____
 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 123
 (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 Master V. Robbins (M. D. or other) U
 Address Belton, Mo. Date signed 9/10/41

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.....

A. R. George

Licensed Embalmer No. 3645

P. O. Address Grandview, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31294

Registration District No. 158

Primary Registration District No. 5223

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Fural
(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
years, months or days) _____

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 Sarah M. 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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 24 1854
(Month) (Day) (Year)

8. AGE: Years 87 Months 1 Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of 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) Sept 29 41 (b) R. M. Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day _____ year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ live on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Chronic Myocarditis

Due to _____

Other conditions Fracture right femur
(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) accident

(b) Date of occurrence Aug 13 41 fell on floor

(c) Where did injury occur? 2630 Passo S.C. Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home slipped on rug
While at work? NO (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-31296 1941