

FILLED OCT 9 1941

Registration District No. **517**

Primary Registration District No. **4192**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Republ. Mo. - Missouri**
(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 **mo** (b) County **Greene 39**
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. **Republic**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **6th**
year **1941** hour **4** minute **A. M.**
21. I hereby certify that I attended the deceased from **August 26th** 1941, to **Sept 6th** 1941;
that I last saw him alive on **Sept 6th** 1941;
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death
Due to **acute myocarditis**
Due to _____

Other conditions **acute indigestion**
(Include pregnancy within 3 months of death)

Major findings:

Of operations **93a**
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?

While at work? _____
23. Signature **[Signature]** (M. D. or other) **9-20**
Address **Republic Mo** Date signed _____

3. (a) PRINT FULL NAME **Eligah Newton Smith**

3. (b) If veteran, name war **V.I.T.** 3. (c) Social Security No. **✓**

4. Sex **male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **divorced**

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

7. Birth date of deceased **May 12 - 1875**
(Month) (Day) (Year)

8. AGE: Years **66** Months **3** Days **24** If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name **David Smith**

13. Birthplace **Tenn**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Livingston**

15. Birthplace **Tenn**
(City, town, or county) (State or foreign country)

16. (a) Informant **E. Phil Logan**

(b) Address **Aurora Mo**

17. (a) **Burial** (b) Date thereof **Sept 9-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wansant Cem. Grove**

18. (a) Signature of funeral director **[Signature]**
(b) Address **Cleaver Mo**

19. (a) **Sept 9** (b) **Mrs Bertha Naves**
(Date received local registrar) (Registrar's signature)

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

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RECEIVED
Greene County Health Office
County File Number 41-10-96
Date Filed 10/6/41

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 J.W. Maple
Licensed Embalmer No. 2985
P. O. Address Chester 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, fact should be so stated above.