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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 1 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32469

Registration District No. 774 Primary Registration District No. 4465 Registrar's No. 1062

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

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1. PLACE OF DEATH:
(a) County St. Francois Mo.
(b) City or town Flat River, Mo.
(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 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Francois
(c) City or town Flat River 094
(If outside city or town limits, write "RURAL") 5
(d) Street No. 2
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 10 years.

3. (a) PRINT FULL NAME Mr. Samuel J. D. Smith.
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White Cave
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased July (Month) 20 (Day) 1858 (Year)

8. AGE:	Years	Months	Days	If less than one day
	84	1	17	hr. min.

9. Birthplace Middlesgeville Hardin Co. Tenn. (City, town, or county) (State or foreign country)
10. Usual occupation Retired Merchant
11. Industry or business at home
MOTHER FATHER
12. Name Amos Smith
13. Birthplace South Carolina (City, town, or county) (State or foreign country)
14. Maiden name Missouri Spencer Smith
15. Birthplace McNairy County - Tennessee (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Arthur McGraw - daughter
(b) Address Flat River, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9 - 1941 (Month) (Day) (Year)
(c) Place: burial or cremation St. Francois Memmorial Cem.
18. (a) Signature of funeral director Alvin W. Hodd
(b) Address Flat River, Mo.
19. (a) 9/7/41 (Date received local registrar) (b) C B Farrar (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 7th year 1941 hour 4 minute 40 P.M.
21. I hereby certify that I attended the deceased from Sept 4, 1941, to Sept 7, 1941; that I last saw him alive on Sept 7, 1941, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hyperstatic Pneumonia	3 hours
Due to Cardiac Decompensation arterial sclerosis - old age	
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 W A Rahlling DD (M. D. or other) DD
Address Flat River Mo. Date signed 9/9/41

(Licensed Embalmer's Statement on Reverse Side)

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 Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address Flat River, Mo.

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
1—8-21-41
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STANDARD CERTIFICATE OF DEATH

State File No. 32469

Registration District No. 774 Primary Registration District No. 4465 Registrar's No.

1. PLACE OF DEATH

(a) County St Francois

(b) City or town Flat River Mo
(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

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 Samuel T. D. Smith

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 (Month) 20 (Day) 1858 (Year)

8. AGE: Years 84 Months 1 Days 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 Sep. day
year 1941 hour minute M.

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

Immediate cause of death Hypostatic Pneumonia (LOBAR) — Duration

Due to

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

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