DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32743

Registration District No. 1125 — Primary Registration District No. 6 0 K — Registrar's No.

1. PLACE OF DEATH:
(a) County: Shannon
(b) City or town: Rural Newton Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 0
(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: Mo (b) County: Shannon
(c) City or town: Rural Newton Tw
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Clarence Balis Smith
3. (b) If veteran, name war: X
3. (c) Social Security No.: X
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Oct (Month) 1 (Day) – 1941 (Year)
8. AGE: Years | Months | Days: 5 | If less than one day ..... hr. ..... min.
9. Birthplace: Shannon (City, town, or county) Mo (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
12. Name (Father): Bunnie Smith
13. Birthplace (Father): Shannon (City, town, or county) Mo (State or foreign country)
14. Maiden name (Mother): Margie Richardson
15. Birthplace (Mother): Tel (City, town, or county) (State or foreign country)
16. (a) Informant: Bunnie Smith
(b) Address: Gladdyne Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 5-1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Ohmeo Cemetery
18. (a) Signature of funeral director: Mrs
(b) Address .....
19. (a) 10-5-41 (Date received local registrar) (b) Frank Hyde M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct day: 5 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.

	Duration
Immediate cause of death: unknown	
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: 0
23. Signature: Frank Hyde (M. D. or other) .....
Address: Cuba Mo Date signed: Oct 12-41

741 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 5,
District File Number 104120.27
Date Filed _____

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 wit the above constitutes grounds for revocation of license.)

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

No. 2B
8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32743

Registration District No. 1125 Primary Registration District No. 6082 Registrar's No.

1. PLACE OF DEATH:
(a) County: Shannon
(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 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: Clarence B. 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
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Oct 1, 1941 (Month) (Day) (Year)
8. AGE: Years | Months | 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
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) (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 day year 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.

	Duration
Immediate cause of death: unknown	
Pneumonia (Bronchial)	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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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