

S. No. 2
W-1-4-41
5-17-39
X23390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42487

State File No. _____

JAN 8 1942

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 324

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
108 North 7th St.
(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 (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town Hannibal
(If outside city or town limits, write "RURAL")

(d) Street No. 108 North 7th St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lela Maude Smith

(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 4
year 1941 hour 5:05 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from August 41, 1941, to 12-4, 1941
that I last saw her alive on Dec 4., 1941
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased: May 25 1890
(Month) (Day) (Year)

Immediate cause of death Brain tumor ✓

Duration	_____
<u>5-6</u>	_____
MO.	_____

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>7</u>	<u>9</u>	_____ hr. _____ min.

9. Birthplace Lewis County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Clark

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 W.C. Smith

(b) Address Hannibal Mo.

17. (a) Burial (b) Date thereof 12 7 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenmount Cemetery Quincy Ill

18. (a) Signature of funeral director James O'Donnell

(b) Address Hannibal Mo.

19. (a) 12-6-41 (b) W.C. Fisher
(Date received local registrar) (Registrar's signature)

Major findings: Brain tumor

Of operations _____

Of autopsy None

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 J.B. Chilton M.D. or other _____
Address 500 Broadway, Hannibal, Date signed 12-6

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

6434

06454

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 Harold M. O'Rourke

Licensed Embalmer No. 3889

P. O. Address Sanibel, Fla

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **432 487**

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No.

1. PLACE OF DEATH: **Marion**
 (a) County: **Marion**
 (b) City or town: **Annibal**
 (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..... (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: **Lela 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: **m**
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased: **May 25 1889**
 (Month) (Day) (Year)

8. AGE: Years **49** Months **7** Days **14** (If less than one day, min.)

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

10. Usual occupation.....

11. Industry or business.....

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..... Year: **1941** hour..... minute..... M.

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

Due to **Brain Tumor**

Due to **malignant**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **548**

Of autopsy.....

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? (Specify type of place) (e) Means of injury.....

23. Signature **J. C. Christon** (M. D. or other)

Address **112 Broadway** Date signed **8/2/41**

SUPPLEMENTARY

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

1944

[The body of the document contains several paragraphs of extremely faint, illegible text. The text is too light to be transcribed accurately.]

CONFIDENTIAL