

FREE APR 24 1942

Registration District No. _____

626 Primary Registration District No. 5828

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Mohaway
(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)
In this community 25 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mohaway
(c) City or town Rural (If outside city or town limit, write "RURAL")
(d) Street No. Samuel, Mo. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12
year 1942 hour 7:00 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug 14, 1943, to March 12, 1942,
that I last saw him alive on March 6, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia with Paralysis

Due to High Blood pressure

Other conditions 83a!

Major findings:
Of operations
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?

While at work? (Specify type of place) (e) Means of injury SA
23. Signature Egbert Crowson (M. D. or other)
Address Samuel, Mo. Date signed Mar 14

3. (a) PRINT FULL NAME CLEM LAIRD SMITH

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased Jan 16 1863 (Month) (Day) (Year)

8. AGE: Years 79 Months 1 Days 26 If less than one day hr. _____ min. _____

9. Birthplace Warren Co. Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Roger Smith

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

14. Maiden name Marion Wilson

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

16. (a) Informant Cora Smith

(b) Address Samuel, Mo.

17. (a) Rural (b) Date thereof 3-14-42 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Samuel Cemetery

18. (a) Signature of funeral director Arch C. Duffell

(b) Address Samuel, Mo.

19. (a) 3-21-1942 (b) Wallace F. Kennedy (Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Arch C. Duffee

Licensed Embalmer No.

3252

P. O. Address

Grant City, 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.