

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Excelsior Springs
 (c) Name of hospital or institution:
716 North Main
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 10 years (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Clay
 (c) City or town Excelsior Springs
 (If outside city or town limits, write "RURAL")
 (d) Street No. 716 N. Main
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Alexander Ballantine Smith

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

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

6. (b) Name of husband or wife Elvina 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Mar 12 1865
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 2 9 hr. min.

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

10. Usual occupation Engineer Hoisting

11. Industry or business Coal Mine

12. Name Alexander Smith

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

14. Maiden name Jessie Ballantine

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

16. (a) Informant David W. Smith

(b) Address 1166 N. Main Excelsior Springs Mo

17. (a) Burial (b) Date thereof 5-22-42
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) *Place: burial or cremation Masonic

18. (a) Signature of funeral director Claude Richard

(b) Address Excelsior Springs, Mo

19. (a) 5-21-42 (b) Miss Sadie Redman
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21
 year 1942 hour 4 am minute 30 a.m.

21. I hereby certify that I attended the deceased from May 16 - 1942
 to May 21 1942
 that I last saw him alive on May 20 - (9 PM) 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Poisoning Duration 5 days

Due to General Arteriosclerosis
Weakness of heart
past 2 to 3 yrs

Due to General Arteriosclerosis

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 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) no

(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 _____

23. Signature Y. D. G. Karen (M. D. or other) _____

Address Excelsior Springs Mo Date signed 5-21-42

1166

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

4
1
1

17760

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 6-9-43

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.....

Claude Prichard

Registered Apprentice No.

working under my personal supervision.

Signed

Claude Prichard

Licensed Embalmer No. 2751

P. O. Address Excelsior Springs, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17760

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs
(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

Alexander 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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar. 12 1864
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month May Day 2 Year 1942 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Strenia Poisoning
Due to never treated when before symptoms
Due to he had chronic nephritis - had convulsions before death
Other conditions _____ (Include pregnancy within _____ months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____

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

23. Signature J. D. Craven (M. D. or other) _____

Address July 9-43 Date signed _____

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

SUPPLEMENTARY

Handwritten text, possibly a signature or name, located in the lower-left quadrant of the page. The text is written in a cursive style and is difficult to decipher due to the high contrast and noise of the scan. It appears to contain several lines of text, possibly including a name and a date or location.

Small handwritten mark or signature at the bottom center of the page.