No. 2
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X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 17 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24459

Registration District No. 384-41 Primary Registration District No. 5-5-35-3025 Registrar's No. 29

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

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains Mo RFD
(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 32 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Howell 46
(c) City or town West Plains 0
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. 0
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Rupert Hadley Smith
3. (b) If veteran, name war ✓
3. (c) Social Security No. 497-12-8878
4. Sex M O
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Lois House Smith
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Nov. 23 1908 (Month) (Day) (Year)

8. AGE: Years 33 Months 2 Days 20 If less than one day ..... hr. ..... min.

9. Birthplace Howell Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer & Employee of Dairy Co.
11. Industry or business
FATHER
12. Name Alvin Smith
13. Birthplace Warren Co. (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Paralee Barnett
15. Birthplace Howell Co. (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Mrs R. H. Smith
(b) Address West Plains Mo
17. (a) B (Burial, cremation, or removal) (b) Date thereof 2/15-42 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope
18. (a) Signature of funeral director Robinson
(b) Address West Plains, Mo
19. (a) 3-12-42 (Date received local registrar) Jack Hadley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 13 P
year 1942 hour 1 minute 30 M.
21. I hereby certify that I attended the deceased from Feb. 6, 1942, to Feb. 13, 1942
that I last saw him alive on February 13, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Tumor	✓
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 W E Hogan (M.D. or other)
Address West Plains, Mo. Date signed 3-12-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 7425-76-
Date Filed 8-14-42.

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 A. D. Kabel

Licensed Embalmer No. 3432

P. O. Address West Point

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

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

S. No. 2B
M—8-21-41
I 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. 24409

Registration District No. 141 Primary Registration District No. 3021 Registrar's No.

1. PLACE OF DEATH:
(a) County: Howell
(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: 33 yrs.

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: Rupert Hadley 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: Nov (Month) 23 (Day) 1909 (Year)

8. AGE: Years 33 Months 2 Days If less than one day hr. min.

9. Birthplace: (City, town, or county) Mo (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 Feb Day 13 year 1943 at 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: Cerebral tumor	
Due to: unknown	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 592	

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)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) 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