

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED AUG 1 1942

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

25551

Do not use this space.

10 PLACE OF DEATH TEXAS  
 (a) County TEXAS Registration District No. 962  
 (b) Township CASS Primary Registration District No. 6193  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME Bedford B. Smith  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Smith  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 4 1861  
 7. AGE YEARS 80 MONTHS 8 DAYS 28 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) Aug 1941 11. Total time (years) spent in this occupation 60  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas  
 FATHER 13. NAME Jim Smith  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TENN.  
 MOTHER 15. MAIDEN NAME Glenn  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TENN.  
 17. INFORMANT (ADDRESS) Edgar Smith  
Solo md.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Steeley Chapel DATE June 4 1942  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gaylord V. Elliott  
Carroll mo  
 20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 2 1942  
 22. I HEREBY CERTIFY, That I attended deceased from April 1 1942 to June 2 1942  
 I last saw him alive on May 15 1942 Death is said to have occurred on the date stated above, at 6:55 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Chronic nephritis  
 Date of onset 1941  
 Other contributory causes of importance: 131 lb  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? No  
 Also, specify \_\_\_\_\_  
 (Signed) Dr. Edgar Smith, M. D.  
Carroll mo  
 (Address) \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 5,

District File Number 742445

Date Filed 7.28.42

oM 2.  
S-8-170  
SX 14

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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.....

*Raymond V. Elliott*

Licensed Embalmer No. 92372

P. O. Address..... *Carroll*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25-551  
Registrar's No. \_\_\_\_\_

Registration District No. 862

Primary Registration District No. 6143

1. PLACE OF DEATH:

(a) County Texas  
(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 Be \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Bedford 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 w  
6. (b) Name of husband or wife May 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 1942  
(Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days \_\_\_\_\_  
(If less than one day \_\_\_\_\_ 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) \_\_\_\_\_ (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) June 4/1942 (b) Mrs Con Miller  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_ 19\_\_\_\_;  
that I observed him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Duration \_\_\_\_\_  
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)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place)  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

