

1 SEP 10 1943

Registration District No. ....

Primary Registration District No. 2003

Registrar's No. 57

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

5  
2  
1

**1. PLACE OF DEATH:**

(a) County Barry

(b) City or town Monett *Missouri*

(c) Name of hospital or institution: 1  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution.....  
(Specify whether years, months or days)

In this community.....  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State..... (b) County 999

(c) City or town..... (If outside city or town limits, write "RURAL") 30

(d) Street No..... (If rural, give location) 0

(e) Citizen of foreign country?..... (Yes or No) 2  
If yes, name country.....

**3. (a) PRINT FULL NAME** Jack Quarles Hewlitt Smith

3. (b) If veteran, name war..... 3. (c) Social Security No. 082-10-3798

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 17 year 1942 hour 4:00 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.

4. Sex Male 5. Color or race W

6. (a) Single, widowed, married, divorced 3 Divorced

6. (b) Name of husband or wife Elizabeth Smith 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased April 8, 1882  
(Month) (Day) (Year)

Immediate cause of death Coronary Artery  
Had the disease since

Due to Dead when found

Due to in Pulmonary Sleeper.

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

Major findings:  
Of operations.....

Of autopsy.....

Duration 7 hrs  
1937

**8. AGE:** Years Months Days If less than one day

60 4 9 hr. min.

9. Birthplace Baltimore, Md. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation President.

11. Industry or business Insulating Products Corp. N. Y.

12. Name J. Q. H. Smith,

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

14. Maiden name Bruce,

15. Birthplace Don't Know 9  
(City, town, or county) (State or foreign country)

16. (a) Informant I. Q. H. Smith, III

(b) Address Brightwater, Long Island, N. Y.

17. (a) Removal (b) Date thereof 8-17-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Portsmouth, Virginia.

18. (a) Signature of funeral director Callaway's

(b) Address Monett Mo.

19. (a) 8-17-1942 (b) Malina Harman  
(Date received local registrar) (Registrar's signature)

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

942

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) Means of injury.....

23. Signature John P. Ellison (M. D. or other) do.  
Address Wheaton Mo Date signed Aug 17, 1942

RECEIVED

District Health Officer No: 6,

District File Number 942-1313

Date Filed SEP 8 1942

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.....

*J. D. Buchanan*  
.....

Registered Apprentice No.....

working under my personal supervision.

Signed *J. D. Buchanan*  
.....

Licensed Embalmer No. 3129

P. O. Address *Monroville Pa.*

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. 26606  
Registrar's No. 57

Registration District No. 13

Primary Registration District No. 3003

1. PLACE OF DEATH:

(a) County Bary  
(b) City or town Monett  
(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)

3. (a) PRINT FULL NAME Jack W. 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 2

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 8  
(Month) (Day) (Year)

8. AGE: Years 60 Months 4 Days 17 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County \_\_\_\_\_  
(c) City or town New York City  
(If outside city or town limits, write "RURAL")  
(d) Street No. not known  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I have a 2 day on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

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?  
\_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MAY 18 1943