

FILED SEP 15 1942 1

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 5550

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town Rural Benton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Eighty years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 46  
(c) City or town Rural Benton 4  
(If outside city or town limits, write "RURAL")  
(d) Street No. Acorns No. 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes/No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 26  
year 1942 hour 4:10 minute 10 A.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.

Immediate cause of death Old Age - Myocarditis  
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 Miss Paulus Loc. Reg. (M, Dr or other)  
Address St. Paul Date signed 8-1-42

3. (a) PRINT FULL NAME Sarrah Smith

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased: Oct 7 (Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation House keeper

11. Industry or business \_\_\_\_\_

12. Name John Smith

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

14. Maiden name Sarah Thompson

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

16. (a) Informant Vane Smith

(b) Address Bakersfield Mo

17. (a) Not at all (b) Date thereof 7-29-42 (Month) (Day) (Year)  
(c) Place: burial or cremation Burial

18. (a) Signature of funeral director H. G. Marler

(b) Address Bakersfield Mo.

19. (a) 8-1-42 (b) Miss Paulus (Registrar's signature)

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

16  
00

RECEIVED

District Health Officer No. 5,

District File Number 942-870

Date Filed 9-14-42

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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 Denver Roller

Licensed Embalmer No. 4006

P. O. Address ava, ind,

**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.**