

FILED SEP 11 1942

Registration District No. **374**

Primary Registration District No. **6-2-7-3 (6274)**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Worth**
 (b) City or town **Worth, Mo. Rural Middlebrook**
 (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 **12 yrs** years, months or days

3. (a) PRINT FULL NAME **Theodore D Smith**

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

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Estella Shuster Smith** 6. (c) Age of husband or wife if alive **61** years
 7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **39** Months **5** Days **22** If less than one day hr. _____ min. _____

9. Birthplace **Terre Haute Ind** (City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business _____

12. Name **William R Smith**
 13. Birthplace **Indiana** (City, town, or county) (State or foreign country)
 14. Maiden name **Mary Yakum**
 15. Birthplace **Indiana** (City, town, or county) (State or foreign country)

16. (a) Informant **Jack M. Smith**
 (b) Address **Worth, Mo**

17. (a) **Burial** (b) Date thereof **Aug 29-42**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Prairie Chapel**

18. (a) Signature of funeral director **Hayes Andrews**
 (b) Address **Worth, Mo**

19. (a) **Aug 31, 1942** (b) **Archie Scadden**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Worth** 113
 (c) City or town **Worth, Mo Rural** 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **26**
 year **1942** hour **4** minute **P.M.**

21. I hereby certify that I attended the deceased from **5-10** 19 **42** to **8-26** 19 **42**
 that I last saw him alive on **8-26** 19 **42**
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Coronary artery disease**
 Duration **1 yr**

Due to **Chronic**
 Due to **124 ft**

Other conditions (Include pregnancy within 3 months of death)
Chronic myocarditis

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 **700**
 23. Signature **Charles A. Williamson** (M.D. or other)
 Address **Worth, Mo** Date signed **8-27-42**

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

Licensed Embalmer No. 2893

P.O. Address

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.