30766

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 184 — Primary Registration District No. 3039 — Registrar's No. 30

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield Mo (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 24 hr. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County Keokuk
(c) City or town Sigourney Iowa (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME Joseph Terry Smith
3. (b) If veteran, name war 1st World War
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clara Smith
6. (c) Age of husband or wife if alive 41 years
7. Birth date of deceased March (Month) 24 (Day) 1899 (Year)

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace ~~La Porte~~ LaMars (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Mail Carrier
11. Industry or business
FATHER
12. Name T. M. Smith
13. Birthplace Marion (City, town, or county) Iowa (State or foreign country)
MOTHER
14. Maiden name Emma Mercer
15. Birthplace Marion (City, town, or county) Iowa (State or foreign country)
16. (a) Informant's own signature X Mrs Roy H. Burdine
(b) Address Sigourney Iowa
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 18-1942 (Month) (Day) (Year)
(c) Place: burial or cremation Sigourney Iowa
18. (a) Signature of funeral director James McLaughlin
(b) Address Marcelline Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1942 hour 9 minute A M.
21. I hereby certify that I attended the deceased from Called as Coroner, 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 Accidently by gas illuminating and	
Due to Cooking gas Poisoning	
Due to (Coroner Jury Verdict)	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 181-1
Of autopsy 35

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) Accident
(b) Date of occurrence Sept 17, 1942
(c) Where did injury occur? Brookfield (City or town) Linn (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? About Reams Camp - 721 W Helm. (Specify type of place)
While at work? no (e) Means of injury
23. Signature Dale Bunch - Coroner (~~M. D. or other~~)
Address Marcelline Mo Date signed 9/17/42

(Licensed Embalmer's Statement on Reverse Side)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

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.....Dale Bunch

Licensed Embalmer No.....4088

P. O. Address.....Marceline

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, above space should be left blank.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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STANDARD CERTIFICATE OF DEATH

State File No. 30764

Registration District No. 184 Primary Registration District No. 3039 Registrar's No. 30

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

1. PLACE OF DEATH:
(a) County: Linn
(b) City or town: Brookfield
(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

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: Joseph Leroy 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: Mar (Month) 24 (Day) 1899 (Year)

8. AGE: Years 43 Months Days If less than one day hr. 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) (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) 9-18-1942 (Date received local registrar) (b) H. N. Cowan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. Day 17 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive 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)
(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