

FILED NOV. 9 1942

State File No. _____

Registration District No. 176

Primary Registration District No. 5433

Registrar's No. 627 J

1. PLACE OF DEATH:

(a) County Lawrence
 (b) City or town Mt Vernon Mo. City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
"Home" "Sharon" "Add"
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution "Home"
(Specify whether
 In this community "Seven days"
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Lawrence
 (c) City or town Mt Vernon "City"
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? NO. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

JAY SMITH

(b) If veteran, NO name war NO
 (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25
 year 1942 hour 5 minute _____ M.
 21. I hereby certify that I attended the deceased from 10/28
1942 to (one visit only)
 that I last saw him alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Ch. Myocarditis + Nephritis with Anasarca

Due to _____
 Due to _____

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

Major findings: Of operations _____
 Of autopsy _____

Duration _____
 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 Summit Glover M.D. (M. D. or other)
 Address Mt Vernon Mo Date signed 11/24/42

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Tarlie Smith 6. (c) Age of husband or wife if alive 51 10 01 years
 7. Birth date of deceased: Jan 5 1891
(Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days 15
 If less than one day _____ hr. _____ min.

9. Birthplace Texas No O
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business Barber

12. Name James Smith
 13. Birthplace Texas U.S.A
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown Unknown
 15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Tarlie Smith
 (b) Address Mt Vernon Mo
 17. (a) City Cem (Burial, cremation, or removal) (b) Date thereof Oct 30 1942
(Month) (Day) (Year)
 (c) Place: burial or cremation Mt Vernon "City Cem"

18. (a) Signature of funeral director H. W. Fousey
 (b) Address Mt Vernon Mo
 19. (a) 10-30-42 (Date received local registrar) (b) Audy Gaudin (Registrar's signature)

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

7-39
K29484

RECEIVED

District Health Officer No. 6,

District File Number 1142-1528

Date Filed NOV 5 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 _____, Registered Apprentice No. _____ working under my personal supervision.

Signed N. D. Fossitt

Licensed Embalmer No. 2201

P. O. Address mt vernon, W

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. 34177
Registrar's No. 25-

Registration District No. 176

Primary Registration District No. 5655

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town mt Vernon
(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)

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 Feb Day 28
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I first saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

3. (a) PRINT FULL NAME Jay 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 Jan 5 1904
(Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days 10 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)

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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?

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-3477 1942