

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11179

State File No. _____

Registration District No. 293Primary Registration District No. 6005Registrar's No. 45

1. PLACE OF DEATH:

(a) County Ralls
 (b) City or town New London, R F D
 (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 Life
 years, months or days

3. (a) PRINT FULL NAME Arthur Wells 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 Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 27 1877
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 4 19 _____ hr. _____ min.

9. Birthplace Ralls Co Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer11. Industry or business Farming

12. Name Ed Smith
 13. Birthplace _____
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Ellis
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Smith
 (b) Address Center Mo
 17. (a) Burial (b) Date thereof 3-18-43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Center Cemetery18. (a) Signature of funeral director Herb Hulse(b) Address Center Mo

19. (a) 3-23 43 (b) R. S. Berkley
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ralls
 (c) City or town New London R F D
 (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? 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 16
 year 1943 hour 9 minute 30p M.

21. I hereby certify that I attended the deceased from March 9 1943 to March 9 1943; that I last saw him alive on March 9 1943 and that death occurred on the date and hour stated above.
 Immediate cause of death Cerebral thrombosis Duration 10 days

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)
 (a) Means of injury _____

23. Signature Herb Hulse (M. D. certificate)
 Address Center Mo Date signed 3/22/43

RECEIVED

District Health Officer No. 10

District File Number

4-43-761

Date Filed

APR 10 1943

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

Giles R. Hulse

Licensed Embalmer No.

4263

P. O. Address

Center Mo

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, above space should be left blank.