

FILED APR 7 1943

State File No.

Registration District No. 316

Primary Registration District No. 3060

Registrar's No. 242

1. PLACE OF DEATH
(a) County St. Francois Co.
(b) City or town Farmington, mo
(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
In this community about 15 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary L. Smith
3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Bert Smith 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased march 27 1885
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 17 If less than one day 10 hr. 5 min.

9. Birthplace Dexter Stoddard Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation Practical nurse

11. Industry or business None
12. Name Mrs. Weston
13. Birthplace Dexter mo
(City, town, or county) (State or foreign country)
14. Maiden name Worthington
15. Birthplace Don't know 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ralph Smith
(b) Address 45447th St. W. St. Louis Mo.
17. (a) Burial (b) Date thereof 3 18 43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dexter mo

18. (a) Signature of funeral director CO 3 centennial Home
(b) Address Farmington, mo
19. (a) mar. 18, 1943 (b) D. Sydnie Burkmaster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State mo (b) County St. Francois
(c) City or town Farmington, mo
(If outside city or town limits, write "RURAL.")
(d) Street No. 208 East 7th St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar. day 16
year 1943 hour 10 minute 05 a.m.

21. I hereby certify that I attended the deceased from Feb 19 1943 to mar 16 1943
that I last saw her alive on mar 13 1943
and that death occurred on the date and hour stated above.

Immediate cause of death acute Eudl. Congestion
Carditis, Pulmonary
congestion
Due to myocarditis, nephros
& hypertension
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy no

Duration 1 day
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 4
23. Signature L. M. Stanfield (M. D. or other) MD
Address Farmington mo Date signed 3/17/43

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

MOTHER FATHER

District Health Officer No... 4
District File Number 443-1978
Date Filed 4-5-43

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.....

me....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Chazan*.....
Licensed Embalmer No. *4084*.....
P. O. Address..... *Farmington*.....

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. 11309
Registrar's No. 242

Registration District No. 316 Primary Registration District No. 3060

1. PLACE OF DEATH:
(a) County St. Francis
(b) City or town Farmington
(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)

3. (a) PRINT FULL NAME Mary J. Smith
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 March 27
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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) _____ (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) _____ (Date received local registrar) (b) _____ (Registrar's signature)

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 March year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above, of immediate cause of death acute Endo. pulmonary

Due to myocarditis, nephritis & hypertension
Due to Chronic

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)

(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 L.M. Stauffer (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY-6

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-11307