

No. 2  
42  
11

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

FILED JUN 7 1943 107  
Registration District No. 107

Primary Registration District No. 3019

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Fessett  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether)

In this community 21 years (years, months or days)

3. (a) PRINT FULL NAME Joe 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 married

(b) Name of husband or wife Ella Smith 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased October 23 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

54 6 15 hr. min.

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

10. Usual occupation Teacher

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Jan Smith

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Joe Smith

(b) Address 615 N. Main Fessett, Mo.

17. (a) Burial (b) Date thereof 5-10-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pine City Cemetery

18. (a) Signature of funeral director Paul Salomon

(b) Address Fessett, Mo.

19. (a) 5-10-43 (b) Julia Blankenship  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin 35

(c) City or town Fessett 31  
(If outside city or town limits, write "RURAL")

(d) Street No. 615 North Main  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8  
year 1943 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 7:11 a.m. to 7:11 a.m. 43  
and that death occurred on the date and hour stated above. 1943

Immediate cause of death: Myocardial Infarction 2 7110  
Decompensation 2 7110

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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 2

23. Signature George J. Schmitt (M. D. or other) 00  
Address Fessett 7110 Date signed 5-8-43

RECEIVED

District Health Office No. 2,

District File Number let 3-726

Date Filed 6-9-43

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**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

*[Handwritten Signature]*

Licensed Embalmer No.

2556

P. O. Address

Keenel, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 107

Primary Registration District No. 3019

Registrar's No. 47

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Kennett  
(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 Joe 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 Oct. 23  
(Month) (Day) (Year)

8. AGE: Years 54 Months \_\_\_\_\_ Days \_\_\_\_\_ 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)

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 Mar Day 19 Year 1940 Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above immediately after death.

Duration \_\_\_\_\_

2 mo

rephritis

decompensation

2 mo

Due to acute pneumococci

Due to rephritis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

130

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (c) Means of injury 7 P D

23. Signature Geo. J. Gilmore (M. D. or other) \_\_\_\_\_

Address 7710 \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

S-17774