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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25597

ED JUL 24 1943
Registration District No. 38

Primary Registration District No. 4355

State File No. _____

Registrar's No. 31

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: No 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No (Specify whether years, months or days)

In this community about 22 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town New Madrid
(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 LELA SMITH

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30
year 1943 hour 3:30 minute _____ P. M.

4. Sex Female

5. Color or race 3 BLACK

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ADAM SMITH

6. (c) Age of husband or wife if alive 69 years (Day) (Year)

7. Birth date of deceased SEPT 15 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 15 1942 to May 30 1943 that I last saw him alive on May 30 1943 and that death occurred on the date and hour stated above.

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

50 8 15 _____ hr. _____ min.

Immediate cause of death Cardiac Failure

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

Due to Abdominal Tumor Malignant (Duration 6 months)

10. Usual occupation Housewife

Due to _____

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

11. Industry or business _____

MOTHER FATHER { 12. Name GEORGE WHITE

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

14. Maiden name unk

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

PHYSICIAN _____

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Adam Smith

(b) Address New Madrid, Mo.

17. (a) Burial (b) Date thereof June 1, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sandhill

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 _____

18. (a) Signature of funeral director Richardson and Co

(b) Address New Madrid, Mo.

19. (a) June 7, 1943 (b) Alice Spitzer
(Date received local registrar) (Registrar's signature)

23. Signature W. L. Riggs (M. D. or other) _____

Address New Madrid Date signed 6-7-43

1031 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Office No. 2,

District File Number 243-89

Date Filed 7-19-43

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Leo Hedgkoth

Licensed Embalmer No. 3803

P. O. Address New Madrid, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State Filing 27 1943

Registration District No. 238

Primary Registration District No. 4365

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town New Madrid
(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 _____

3. (a) PRINT FULL NAME Sela Smith

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) _____ (Year) _____

7. Birth date of deceased Sept 15 (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 00 Months 8 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 _____ (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I have seen him alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure Duration _____

Due to abdominal tumor malignant

Due to _____

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

Major findings: Of operations 55

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? abdominal tumor, year in bed

While at work? See home (Specify type of place) (e) Means of injury no injury

23. Signature Dr. H. L. Wiggin (M. D. or other) _____

Address New Madrid Mo. Date signed 7-29-43

SUPPLEMENTARY

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

MOTHER FATHER

S 25597