DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26288

Registration District No. 333 Nienstedt

Primary Registration District No. 3074

Registrar's No.

LED JUL 26 19[illegible]

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston (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 years, months or days) In this community life time

2. USUAL RESIDENCE OF DECEASED: 100

(a) State Missouri (b) County Scott 5

(c) City or town Sikeston 2 (If outside city or town limits, write "RURAL")

(d) Street No. sunset Adition (If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Willie Jean Smith

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex F

5. Color or race 3 C

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

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

7. Birth date of deceased 6 (Month) 7 (Day) 1924 (Year)

8. AGE: Years 19 Months 0 Days 10 If less than one day hr. min.

9. Birthplace Sikeston (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Columbus Smith
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Mary
15. Birthplace (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mary Smith

(b) Address Sikeston Mo. Gen. Del.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/43 (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo.

18. (a) Signature of funeral director H.W. Albritton

(b) Address Sikeston Mo

19. (a) 7-3-43 (Date received local registrar) (b) Louie Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 17 year 1943 hour 8 minute a M.

21. I hereby certify that I attended the deceased from May 1, 1943, to June 17, 1943 that I last saw her alive on June 4, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to Pregnancy + Childbirth

Due to Pneumonia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature [illegible] (M. D. or other)

Address Sikeston Mo Date signed 6-24-43

1318

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 743-862
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: John Albritton

Licensed Embalmer No. 2940

P. O. Address Sikeston Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co[illegible] the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 333 Primary Registration District No. 3074 Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(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 years, months or days) In this community

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 Willie Jean 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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 7 (Day) 1928 (Year)

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

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 7 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-26288