

No. 2  
-5-42  
-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED SEP 8 1943**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **29156**  
Registrar's No. **17**

Registration District No. **298** Primary Registration District No. **6023**

**1. PLACE OF DEATH:**  
(a) County **Ray**  
(b) City or town **Rural Howardtown**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **all his life** years, months or days \_\_\_\_\_ (Specify whether)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State \_\_\_\_\_ (b) County **89**  
(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** **Nora Bell Smithey**  
**3. (b) If veteran,** name war **✓**  
**3. (c) Social Security** No. **F**

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **August** day **8** year **1943** hour **9 PM** minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** **June 10** 1943 to **Aug 8** 1943 that I last saw him alive on **Aug 7** 1943 and that death occurred on the date and hour stated above.

**4. Sex** **Female** **5. Color or race** **wh** **6. (a) Single, widowed, married,** **2 divorced widowed**  
**6. (b) Name of husband or wife** **Gas. B. Smithey** **6. (c) Age of husband or wife if** \_\_\_\_\_ **alive** \_\_\_\_\_ years  
**7. Birth date of deceased** **May 17 - 1870**  
(Month) (Day) (Year)

Immediate cause of death **Adeno Carcinoma of abdomen.**  
Due to **Primary adeno Carcinoma of Rt ovary**  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Duration **As not known**  
Physician **As not known**

**8. AGE:** Years **73** Months **2** Days **21** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** **Ray co mo** (City, town, or county) (State or foreign country)

**10. Usual occupation** **Retired**

**11. Industry or business**

**12. Name** **Henry clay King**

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

**14. Maiden name** **Jane Thompson**

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

**16. (a) Informant** **Mrs Ethel wall**

**(b) Address** **Pals mo**

**17. (a) Burial** (Burial, cremation, or removal) **(b) Date thereof** **8-10-43** (Month) (Day) (Year)

**(c) Place: burial or cremation** **Richmond mo**

**18. (a) Signature of funeral director** **Alapangh Cowley**

**(b) Address** **Pals mo**

**19. (a) 8-10-43** (Date received local registrar) **(b) Waplesh** (Registrar's signature)

**Major findings:** **General Carcinomatous of abdomen**  
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) Means of injury \_\_\_\_\_  
**23. Signature** **Chas W. Wall** (M.D. or other) \_\_\_\_\_  
**Address** **Pals mo** Date signed \_\_\_\_\_

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

MOTHER FATHER

1143

RECEIVED

Director Health Officer No. 8

Case File Number

Date Filed

9-7-43

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

A. B. Cowley

Licensed Embalmer No.

1015

P. O. Address

Palo Alto

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.

Registration District No. 298 Primary Registration District No. 6023

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Rural (Knoxville)  
(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

Nora Bell Smithey

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

4. Sex F 5. Color or race N 6. (a) Single, widowed, married, divorced N  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 17 (Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days 12 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

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) M. Black (Registrar's signature)  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray  
(c) City or town Rural (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? N (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1943 day \_\_\_\_\_ 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.  
Immediate cause of death \_\_\_\_\_

Duration

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

FILED SEP 10

2915b