S. No. 2
9-4-41
17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41977

Registration District No. FILED DEC 17 1943

Primary Registration District No. 4126

Registrar's No. 83

1. PLACE OF DEATH:

(a) County Clark

(b) City or town Wyaconda, Mo.
(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: 23

(a) State ..... (b) County 0

(c) City or town 0
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME Albert Smulling

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mable Smulling

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased May (Month) 8 (Day) 1871 (Year)

8. AGE: Years 72 | Months 6 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Knox County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Painter and day laborer

11. Industry or business .....

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

MOTHER
14. Maiden name Don't Know
15. Birthplace ..... (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mable Smulling
(b) Address Wyaconda, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Wyaconda, Mo.

18. (a) Signature of funeral director Gerth & Baskett
(b) Address Wyaconda, Mo.

19. (a) 11-30-43 (Date received local registrar) (b) Perry S. Borton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15
year 43 hour 10:8 a.m. minute ..... M.

21. I hereby certify that I attended the deceased from June 1, 1938, to Nov. 15, 43
that I last saw him alive on Nov 15 — 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pernicious Anemia
unknown

Due to .....

Due to .....

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.

73a

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 2

23. Signature Dr. B. F. Hutchinson (M. D. or other) D.O.

Address Wyaconda, Mo. Date signed 11/30/43

1273 (Licensed Embalmer's Statement on Reverse Side)

JAN 2 0 1944

RECEIVED
District Health Officer No. 10
District File Number 12-43-1997
Date Filed DEC 1 5 1943

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 Geo V. Boskett

Licensed Embalmer No. 1817

P. O. Address Wyaconda,

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

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

S. No. 2B
OM—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. Jan

Registration District No. 70 Primary Registration District No. 4126 Registrar's No. 83

1. PLACE OF DEATH:

(a) County Clark

(b) City or town Wyaconda
(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 missouri (b) County Clark

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

(d) Street No. 330 West Jefferson St
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Albert Smulling

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 May (Month) 8 (Day) 1887 (Year)

8. AGE: Years 72 Months 6 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 Nov Day 1-
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-41977