

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42202
Registrar's No. 1033

X26390

Registration District No. 1011-11-1943-128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County GREENE
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
459 E. Harrison /
 (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 32 years
 years, months or days)

3. (a) PRINT FULL NAME Mary McCaleb Smith
 3. (b) If veteran, name war. None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Widowed
 6. (b) Name of husband or wife Hal O. Smith 6. (c) Age of husband or wife if alive Deceased years
 7. Birth date of deceased June 12, 1873
 (Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 7 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business In Home

12. Name Jerry McCaleb

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

14. Maiden name Sarah Jane Bobb

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

16. (a) Informant Mr. Elton Smith
 (b) Address Springfield, Missouri

17. (a) Cremation (b) Date thereof Dec. 21, 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Louis Missouri

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
 (b) Address Springfield, Missouri

19. (a) 12-20-43 (b) B. W. Haulley
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 39
 (a) State Missouri (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 459 E. Harrison
 (If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month December day 19th,
 year 1943 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from Dec 14 1943 to Dec 19 1943
 that I last saw her alive on Dec 19 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Duration 6 days

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

Major findings: 330
 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) _____ (e) Means of injury _____
 23. Signature J. B. Bruton (M. D. or other) MD
 Address Springfield, Mo Date signed Dec 20

W 1943

JAN 2 01944

OCT 17 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 Harlow Knapp

Licensed Embalmer No. 4065

P. O. Address Springfield 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.

X