

S. No. 2  
M-5-43  
7-5-17-39  
X38671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 43143

FILED JAN 6 1945

Primary Registration District No. 0-8/3

Registrar's No. 16

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

1. PLACE OF DEATH:

(a) County Montgomery  
 (b) City or town Rural Wellsville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Upper South In  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community 3 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Montgomery  
 (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? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES THOMAS SMITH.  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov, day 30  
 year 1945 hour 5 minute 30 P.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.

4. Sex M 5. Color or Race W  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if divorced Single  
 7. Birth date of deceased June 10 1868  
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis? Duration  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

8. AGE: Years 75 Months 5 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Callaway Co Mo (City, town, or county) (State or foreign country)

Other conditions 9/4a  
(Include pregnancy within 3 months of death)  
 Major findings: 9/4a  
 Of operations \_\_\_\_\_  
 Of autopsy None

10. Usual occupation Laborer  
 11. Industry or business Rural Labor  
 12. Name John X Smith  
 13. Birthplace Kentucky  
 14. Maiden name Lucinda Brett  
 15. Birthplace Callaway Co Mo  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mar F. Moran  
 (b) Address Wellsville Mo  
 17. (a) Rural (b) Date thereof Dec 1 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Wellsville Mo  
 18. (a) Signature of funeral director F W Kuhn  
 (b) Address Wellsville Mo  
 19. (a) Dec 1-1945 (b) Mrs Virginia Norton  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) No  
 (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 T O Han aty (M. D. or other)  
 Address Wellsville Mo Date signed 11/30/45

1045

**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.....

Licensed Embalmer No. *3059*

P. O. Address *Wellsville 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.**