

FILED JAN 19 1943  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Jackson  
(b) City or town Keokuk  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Research Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 Days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Keokuk  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1915 E 24th  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME TIMOTHY B. SMITH

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

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Infant  
6. (b) Name of husband or wife Fred Smith 6. (c) Age of husband or wife if alive 23 years  
7. Birth date of deceased Dec 19 1943  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 1943 year  
hour 3:32 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Dec 19 1943 to Dec 29 1943  
that I last saw him alive on Dec 28 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Menstruation due to Spina Bifida Hydrocephalus (Congenital) Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months 11 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Fred Smith

13. Birthplace Sioux City Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Jane Williams

15. Birthplace Sioux City Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Smith

(b) Address 1415 East 24th Keokuk Mo

17. (a) Burial (b) Date thereof Dec 31 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sioux City Iowa

18. (a) Signature of funeral director Morton Rame

(b) Address No 10 Keokuk Mo

19. Dec 30 1943 (c) J. C. Brown  
(Date received local registrar) (Registrar's signature)

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) Means of injury \_\_\_\_\_

23. Signature J. W. Muller (M. D. or other) MD

Address 1016 1/2 W. 24th Date signed \_\_\_\_\_

**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 J. Morte*

Licensed Embalmer No. *4349*

P. O. Address. *no ke*

**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.**