

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 28 1944

Primary Registration District No. 5655

Registrar's No. 1

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Mt Vernon Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo State Sanatorium
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 1984 days
In this community 1984 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. 1201 Walnut
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Delbert Vern Smith
(b) If veteran, name war no
(c) Social Security No. unknown

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 2
year 1944 hour 6 minute 15 A M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive years

21. I hereby certify that I attended the deceased from Jan 9th, 1944, to Jan 2 1944 that I last saw him alive on Jan 7, 1944 and that death occurred on the date and hour stated above.

7. Birth date of deceased July 14 1906
(Month) (Day) (Year)
8. AGE: Years 37 Months 5 Days 18 If less than one day hr. _____ min. _____

Immediate cause of death Myo-carditis (Sub-acute) Pulmonary tuberculosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 13 fl.

9. Birthplace Brooklyn Iowa
(City, town, or county) (State or foreign country)
10. Usual occupation Clerk

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business Drug Store
12. Name James Smith
13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name Pearl Goff
15. Birthplace Janesville, Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Michael Reed Clark
(b) Address Mo State San Mt Vernon Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 1944
(Month) (Day) (Year)
(c) Place: burial or cremation Burial State San

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? _____

18. (a) Signature of funeral director Geo B Orr
(b) Address Mt Vernon Mo
19. (a) 1-5-44 (Date received local registrar) (b) Andy Oswald (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature Y. F. Fujikawa (M. D. or other) MD
Address Mt Vernon, Mo Date signed 1/2/44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 144-87

Date Filed 7/1 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....
Or anyone....., Registered Apprentice No.....
working under my personal supervision.

Signed Geo. B. Orr

Licensed Embalmer No. 946

P. O. Address 7 Am Vernon M

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.