

No. 2
-2-43
-17-39

FILED MAR 14 1944
Registration District No. **1046**

Primary Registration District No. **5237**

Registrar's No. **13**

1. PLACE OF DEATH
 (a) County Cedar
 (b) City or town Rural Cedar Line
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 mo
(Specify whether years, months or days)
 In this community 6 mo

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

3. (a) PRINT FULL NAME WILLIAM F. SMITH
 (b) If veteran, name war -
 (c) Social Security No. -

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 2 day 14
 year 1944 hour 8 minute 30
 21. I hereby certify that I attended the deceased from Feb 7
1944 to Feb 14 1944
 that I last saw him alive on Feb 13 1944
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Sarah E. Smith
 (c) Age of husband or wife if alive 76 years
 7. Birth date of deceased: Sept 15 1862
(Month) (Day) (Year)

Immediate cause of death Pneumonia
 Duration

8. AGE: Years 81 Months 4 Days 29
 If less than one day hr. min.

Due to
 Due to

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

10. Usual occupation School Teacher

Other conditions
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations
 Of autopsy

11. Industry or business

12. Name James M. Smith

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

14. Maiden name Reta Johnson

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

16. (a) Informant Oliver Smith

(b) Address Sulsa Okla

17. (a) Buried (b) Date thereof 2/15/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Ed Dorado Spags
 (b) Address 2116 1st

19. (a) 2116 1st (b) H. L. Blumway
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury 2
 23. Signature J. P. W. ... (M. D. or other) 40
 Address Ed Dorado Spags Date signed Feb 16, 44

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

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1046

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 61 Primary Registration District No. 5237 Registrar's No. 13

1. PLACE OF DEATH:
(a) County Cedar
(b) City or town Rural Cedar Jump
(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 _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wm F Smith
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 7 year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.
Immediate cause of death pneumonia Duration 2 days

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 Sept 15 (Month) (Day) (Year)

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years 81 Months 4 Days _____ (Unless than one day) min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

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 _____

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

23. Signature J. O. Williams or other _____
Address 108 E. 10th St. St. Louis Date signed 3-15-44

SUPPLEMENTARY

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

MOTHER FATHER

08417