

S. No. 2
1-1-4-41
5-17-39
PI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 8 1944

Registrar's No. _____

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Buffalo Rural
(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 12 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Buffalo Rural
(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 ELLA SMITH

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

4. Sex Female 5. Color or race White 6. (a) Single (b) Widowed (c) Divorced (d) Married
7. Birth date of deceased March 15 1870
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Archie Stearns

(b) Address Buffalo Mo

17. (a) Burial (b) Date thereof Feb 26 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lindley

18. (a) Signature of funeral director L B Jones

(b) Address Buffalo Mo
19. (a) 3-1-1944 (b) L B Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24
year 1944 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan. 2, 1944 19. to Feb. 24, 1944 19. ;
that I last saw her alive on Feb. 24, 1944 19. ;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis with insufficiency of all valves. ?

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 8 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration

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 ?

23. Signature [Signature] (M. D. or other) DO
Address Buffalo, Missouri Date signed 3/3/44

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

30
0
0

7021

STATE OF MISSISSIPPI
Department of Health
Office of the State Health Officer
2-44-246
2-7-44

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.....

P. O. Address.....

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.