

FILED MAR 8 1944
Registration District No.

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Lebanon
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede ⁵³

(c) City or town Lebanon
(If outside city or town limits, write "RURAL")

(d) Street No. R#2 Harrison St. ⁰
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____ ¹

3. (a) PRINT FULL NAME CALVIN C. SMITH

3. (b) If veteran, name war ✓

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5
year 1944 hour 8 minute 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. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Nora B. Smith

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased July 14 1873
(Month) (Day) (Year)

Immediate cause of death Carbolic acid Poison ^{Duration}

8. AGE: Years Months Days If less than one day

70 6 11 hr. _____ min.

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace Bradley Michigan ^{(City, town, or county) (State or foreign country)}

10. Usual occupation Labourer

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations _____

Of autopsy _____

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

11. Industry or business _____

12. Name William H. Smith

13. Birthplace Mich. ^{(City, town, or county) (State or foreign country)}

14. Maiden name Hulda Harris

15. Birthplace Mich. ^{(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 3

23. Signature James S. Stanton ^(M.D. or other)
Address Lebanon Mo. Feb 8-44 Date signed _____

16. (a) Informant Sherman W. Smith

(b) Address Lebanon mo. R#5

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-44
(Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery Lebanon

18. (a) Signature of funeral director W.E. Halman

(b) Address Lebanon mo.

19. (a) Mar. 2-44 (Date received local registrar) (b) Grace Roper (Registrar's signature)

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

Received

Laclede County Health Unit

File No. 2-44-2f

Date Filed 3/7/44

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____ FILED MAR

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(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)

3. (a) PRINT FULL NAME Calvin C. Smith

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

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 _____ year

7. Birth date of deceased July 14 18
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 21 If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 8 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 Carbolic acid Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence Feb 8 - 44

(c) Where did injury occur? He drank 2 1/2 Carbolic acid
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, or public place?
His Home in Lebanon

While at work? NO (Specify type of place) (e) Means of injury _____

23. Signature J. S. Stanton (M.D. or other) Coroner

Address Lebanon Mo Date signed _____

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

SUPPLEMENTARY INFORMATION

1637

10

7552