

FILED MAR 8 1944
325

Registration District No.

Primary Registration District No. 4476

Registrar's No. 5

1. PLACE OF DEATH: *Schuyler*

(a) County *Schuyler*

(b) City or town *Dorning*
(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..... (Specify whether
In this community *70 years*..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *mo* (b) County *Schuyler*

(c) City or town *Dorning*
(If outside city or town limits, write "RURAL.")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country *d*

3. (a) PRINT FULL NAME *Josiah Edward Smart*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Feb* day *10*
year *1944* hour..... minute..... M.

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 *May 14 1871*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Jan 31 1944 to *Feb 31 1944*;
that I last saw him alive on *Jan 31 1944*
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
72 *8* *26* hr. min.

Immediate cause of death *Myocardial Degeneration*

Due to.....

Due to.....

9. Birthplace *Scotland Co mo*
(City, town, or county) (State or foreign country)

10. Usual occupation *Retired Farmer*

Other conditions *Paralysis of lower Back*
(Include pregnancy within 3 months of death)

11. Industry or business.....

12. Name *Josiah Smart*

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

14. Maiden name *Elizabeth Kasper*

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

Major findings:
Of operations.....
Of autopsy..... *938*

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

16. (a) Informant *Samuel Smart*
(b) Address *Dorning mo*

17. (a) *Burial* (b) Date thereof *Feb 12 1944*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Dorning*

18. (a) Signature of funeral director *Loyal Moore*
(b) Address *Dorning mo*

19. (a) *Feb 12 1944* (b) *P. C. Justicee*
(Date received local registrar) (Registrar's signature)

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 *R. E. Vaughn* (M. D. or other) *DO*
Address *Lancaster, mo* Date signed *2/12/44*

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 3-44-489

Date Filed MAR 7 1944

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed Lloyd Moore

Licensed Embalmer No. 3151

P. O. Address Douning 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.