

FILED APR 7 1944

Primary Registration District No. 4771

Registrar's No. 18

1. PLACE OF DEATH: *Holt*

(a) County: \_\_\_\_\_

(b) City or town: *Mound city*  
(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) *85 yrs*

2. USUAL RESIDENCE OF DECEASED:

(a) State: *Missouri* (b) County: *Holt* 44

(c) City or town: *Mound City* 0  
(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: \_\_\_\_\_ 0

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME: *Mary Emiline Smith*

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No.: \_\_\_\_\_

20. DATE OF DEATH: Month *3* day *4* year *1944* hour *10 AM* minute \_\_\_\_\_ M.

4. Sex: *Female* 5. Color or race: *White* 6. (a) Single, widowed, married: *2 divorced Widowed*

6. (b) Name of husband or wife: *Deceased* 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years

7. Birth date of deceased: *August 6 1854*  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Feb 15* 1944, to *March 3* 1944, that I last saw her alive on *March 2* 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: *Bronchial pneumonia 6 days*

8. AGE: Years *89* Months *6* Days *28* If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to: *Infarction*

Due to: \_\_\_\_\_

9. Birthplace: \_\_\_\_\_ (City, town, or county) *Indiana* (State or foreign country)

10. Usual occupation: *House Work*

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death) *330*

11. Industry or business: \_\_\_\_\_

Major findings: \_\_\_\_\_ Of operations: \_\_\_\_\_

12. Name: *John Shunk*

Of autopsy: \_\_\_\_\_

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

14. Maiden name: *unknown*

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

16. (a) Informant: *Samuel M. Smith*

(b) Address: *Mound City*

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? \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: *3-6-44* (Month) (Day) (Year)

(c) Place: burial or cremation: *W.D. Kopp*

18. (a) Signature of funeral director: *James H. Pettigrew*

(b) Address: *Oregon Mo.*

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature: *F E Hooper* (M. D. or other)

Address: *Mound City* Date signed: *3/5/44*

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 *James H. Pettigrove*

Licensed Embalmer No. *3192*

P. O. Address *Oregon 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.**