

FILED APR 19 1944

Registration District No. 270

Primary Registration District No. 2050

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town Caruthersville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
None.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None. (Specify whether
In this community 40 years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Jacob L. Smith

3. (b) If veteran, name war None. 3. (c) Social Security No. None.

4. Sex Male 5. Color or race Black 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary E. Smith 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased December 24, 1959
(Month) (Day) (Year)

8. AGE: Years 84 Months 2 Days 5 If less than one day
hr. min.

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

10. Usual occupation Farmer
Same as above

11. Industry or business

12. Name Scott Moore
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Sylvia Moore 9
(City, town, or county) (State or foreign country)
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mary E. Smith
(b) Address Caruthersville, Mo.

17. (a) Burial (b) Date thereof 3-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caruthersville, Mo.

18. (a) Signature of funeral director J. L. [Signature]
(b) Address Caruthersville, Mo.

19. (a) 3-12-1944 (b) Jessie N. Markey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot 28
(c) City or town Caruthersville
(If outside city or town limits, write "RURAL")
(d) Street No. East 15th St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country Citizen of U.S.A.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 29,
year 1944 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from
Jan. 5 1943 to Feb. 29 1944
that I last saw him alive on Jan. 20 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hyper-tension - Paralysis
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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) (a) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Caruthersville, Mo. Date signed 3/10/44

126k

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

3-44-67

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.....

Jacob Kelley

Licensed Embalmer No. 3788

P. O. Address Hayth. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 270 Primary Registration District No. 2060

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

1. PLACE OF DEATH:

(a) County Pemiscot

(b) City or town Carthageville
(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 _____ (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 Jacob L. Smith

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

4. Sex m 5. Color or race B 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 Dec 24 1904
(Month) (Day) (Year)

8. AGE: Years 84 Months 2 Days _____ If less 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)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 Day 19 Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension & paralysis Duration _____

Due to Paralysis agitans

Due to _____

Other conditions (Include pregnancy within 3 months of death) 87c

Major findings: Of operations _____

Of autopsy _____

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 Geo. Phelps (M.D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

11692