

S. No. 2
DM-2-43
v. 5-17-39
P-1 X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 12 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12331**
Registrar's No. **36**

Registration District No. **337**

Primary Registration District No. **4499**

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

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Shelbina, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Simpsons Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Six weeks
(Specify whether years, months or days)

In this community 12 veras

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby

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

(d) Street No. 5 miles N.E. Shelbina
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME John Reinhart Smith

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7th
year 1944 hour 1 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan 25
1944 to March 7 1944
that I last saw him alive on March 7 1944
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Jove Smith 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased April 16 1878
(Month) (Day) (Year)

Immediate cause of death Acute myocarditis 6 weeks
Duration

8. AGE: Years 65 Months 10 Days 21 If less than one day hr. min.

Due to Chronic nephritis & hypertension

Due to _____

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

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

10. Usual occupation Farming

Major findings: Of operations 131 R

Of autopsy _____

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

11. Industry or business Same

12. Name Joseph Smith

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

14. Maiden name Mary A. Hoffman

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

16. (a) Informant Mrs. John R. Smith
(b) Address Shelbina, Mo.

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

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

(b) Date of occurrence _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-1944
(Month) (Day) (Year)

(c) Place: burial or cremation Liberty Ill

(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? _____
(Specify type of place)

18. (a) Signature of funeral director William B. Barkley
(b) Address Shelbina, Mo.

19. (a) Med 844 (Data received local registrar) (b) Magaliosch (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury 0

22. Signature D. L. Simpson (M. D. or other) 0
Address Shelbina Mo Date signed Mar 8 1944

RECEIVED

District Health Officer No. 10

District File Number 4-44-789

Date Filed APR 11 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

E. W. Hawkins

Licensed Embalmer No. 3498

P. O. Address.....

Shelburne, 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.