

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14638

State File No.

FILED MAY 11 1944  
228

Registration District No.

Primary Registration District No. 4194

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Genesee  
(b) City or town Albany  
(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 Life years, months or days

3. (a) PRINT FULL NAME James Sella Smith  
3. (b) If veteran, name war No.  
3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Rosa Wilson 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased Sept. 23 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 7 6 hr. min.

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

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER { 12. Name Milton Smith  
13. Birthplace unknown Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Lambert  
15. Birthplace unknown Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. S. Smith  
(b) Address Albany, Mo.  
17. (a) Burial (b) Date thereof 8/1/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview

18. (a) Signature of funeral director Clifford Smith  
(b) Address Albany, Mo.

19. (a) 5/4/1944 (b) Ammer Tr. Decker  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Genesee  
(c) City or town Albany (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29  
year 1944 hour 10 minute 50 P.M.

21. I hereby certify that I attended the deceased from April - 16 -  
1944 to April - 29 - 1944

that I last saw him alive on April 29 - 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 1 week

Due to Ch. nephritis 2 weeks

Due to Ca. prostate 1 year

Other conditions Myocarditis 2 years  
(Include pregnancy within 8 months of death)

Major findings:  
Of operations  
Of autopsy  
1316  
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 Frank H. Rose (M. D. or other) M.D.  
Address Albany Mo. Date signed 5-1-44

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

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 Chaffin Burks  
Licensed Embalmer No. 3329  
P. O. Address Altany 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.**