

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 10

Registration District No. 57
Primary Registration District No. 5209

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

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town rural - Leslie Twp
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Carroll
(c) City or town Bogard - rural
(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 _____

3. (a) PRINT FULL NAME JOSHUA ALTON SMITH
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or Grace W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife MARY ELLEN SMITH 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY 19 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 11 19 _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) MO O (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER { 12. Name James Smith
13. Birthplace MO O (City, town, or county) (State or foreign country)

FATHER { 14. Maiden name Smith
15. Birthplace MO O (City, town, or county) (State or foreign country)

16. (a) Informant Mary Ellen Smith
(b) Address Bogard

17. (a) Buried (b) Date thereof May 12 - 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Braden

18. (a) Signature of funeral director Edwards
(b) Address Bogard

19. (a) 5-11-44 (b) Mrs Edges Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April - 1944
year May 10 - 1944 minute _____ M.
21. I hereby certify that I attended the deceased from April 12 - 1944
May 8 1944 to _____ 19____
that I last saw him alive on May 8 - 1944
and that death occurred on the date and hour stated above.

Immediate cause of death carcinoma
Left Prostate
Due to _____

Due to not known

Other conditions (Include pregnancy within 3 months of death) 55

Major findings: Of operations _____
Of autopsy no autopsy

Duration
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 J. D. Seibel (M. D. or other) _____
Address Chillicothe Mo Date signed 5-10-44

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.