

FILED JUN 19 1944

Primary Registration District No. 3078

Registrar's No. 332

1. PLACE OF DEATH:

(a) County Linn

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

(c) Name of hospital or institution: 116 S Caldwell
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 24 Yrs years, months or days

3. (a) PRINT FULL NAME Alice Blanche Smith

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

4. Sex M 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Dec 25 1892
(Month) (Day) (Year)

8. AGE: Years 51 Months 5 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

MOTHER FATHER

12. Name Ted Lintz

13. Birthplace Boone County Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Whiteside

15. Birthplace Boone County Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Marcellus Smith

(b) Address Brookfield Mo

17. (a) Burial (b) Date thereof May 29 1944
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resful Cemetery

18. (a) Signature of funeral director Clayton Lawton

(b) Address Brookfield Mo

19. (a) 5-29-44 (b) H. H. Cavan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58

(c) City or town Brookfield Mo 2
(If outside city or town limits, write "RURAL")

(d) Street No. 116 S Caldwell
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26
year 1944 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from 5/22/44 19____; to 5/25/44 19____; that I last saw h. alive on 5/25/44 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration _____

Due to acute nephritis

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) (e) Means of injury _____

23. Signature H. S. Willis (M. D. or other) DD
Address Linn Date signed 5/26/44

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Homer Bowden*.....
Licensed Embalmer No..... *3295*.....
P. O. Address..... *Crosbyfield Pa*.....

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.

Registration District No. 184 Primary Registration District No. 3028

1. PLACE OF DEATH:
(a) County Lin
(b) City or town Brookfield
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Alice B. Smith
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 25 (Month) (Day) (Year)

8. AGE: Years 51 Months 5 Days 10 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Specify type of place)
(c) Place; burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Data received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month mar 1944 year. 4 hour 4 minute 6 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 Memor acute nephritis

Due to _____
Due to chronic nephritis
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
1312

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTAL

JUN 1944

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