

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 23 1944
Registration District No. 59

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State Plate No. _____
Registrar's No. 95

Primary Registration District No. 5219

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

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Garden City Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Camp B. ...
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community _____ years, months or days)

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

4. Sex M 5. Color or race Wh 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 10 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months 10 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____
12. Name Ralph Smith
13. Birthplace Garden City Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Zena May Schaefer
15. Birthplace Garden City Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Smith
(b) Address Garden City Mo.
17. (a) Burial (b) Date thereof 6 9 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Deerfork Cemetery
18. (a) Signature of funeral director A. B. ...
(b) Address East ... Mo.
19. (a) June 14, 1944 (b) Margaret Tolle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cass 19
(c) City or town Garden City Rural 2
(If outside city or town limits, write "RURAL")
(d) Street No. X (If rural, give location)
(e) If foreign born, how long in U. S. A. X 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 7
year 1944 hour 8 minute 0 A.M.

21. I hereby certify that I attended the deceased from June - 7 1944 19
that I last saw him alive on baby dead 19
and that death occurred on the date and hour stated above.

Immediate cause of death Choked in a baby's high chair
Due to _____
Due to _____
Other conditions: 182-2
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) accident 019
(b) Date of occurrence June 7, 1944
(c) Where did injury occur Garden City Cass Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - (choked in baby's high chair)
While at work? _____ (Specify type of place) (e) Means of injury high chair
23. Signature: Frank B. Ellis M.D.
Address Garden City, Mo Date signed June 7, 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

A. P. Hartzler

Licensed Embalmer No. *2717*

P. O. Address *East Lyme 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, above space should be left blank.