

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 11 1944

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. _____

1. PLACE OF DEATH

(a) County Pike
(b) City or town Lemouana
(c) Name of hospital or institution Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike Co.
(c) City or town Lemouana
(If outside city or town limits, write "RURAL")
(d) Street No. 1000 Georgia
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME MRS EFFIE STAMBAUGH SMITH

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife W. A. Smith deceased 6. (c) Age of husband or wife if deceased _____ years

7. Birth date of deceased December 13th 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>7</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace Green Castle Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Chilij Stambaugh
13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Susan Clark
15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. H. McLune

(b) Address 1000 Georgia St.

17. (a) Burial (b) Date thereof 9-16-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Riverside Cemetery

18. (a) Signature of funeral director J. C. Heenan

(b) Address Lemouana Mo.

19. (a) 9-15-44 (b) J. C. Heenan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14
year 1944 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 9, 1944 to Sept. 14, 1944
that I last saw her alive on 9-14-44 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Chronic Hypertrophy</u>	
<u>Chronic Myocarditis</u>	<u>4 mo</u>
Due to <u>Chronic Valvular Disease</u>	" "
<u>Glomerular Nephritis</u>	" "
Due to <u>Encephalitis (non specific)</u>	<u>2 wks</u>
Other conditions: <u>Ch. Arteriosclerosis</u>	<u>15 yrs</u>
(Include pregnancy within 3 months of death)	

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN 1318
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)
(a) Means of injury _____

23. Signature Robert A. Hudra M.D.
Address Lemouana Mo. Date signed 9-15/44
(M. D. number)

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

RECEIVED
District Health Officer No. 10
District File Number 10-44-1726
Date Filed OCT 10 1948

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.....

working under my personal supervision.

George O. Hagner

Registered Apprentice No.

Signed *George O. Hagner*

Licensed Embalmer No. *20713*

P. O. Address *Levenson, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.,