

3-2
2-43
7-39
35897

Registration District No. 360 Primary Registration District No. 3076

1. PLACE OF DEATH:
(a) County Vermon
(b) City or town Nevasa
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
633 E. Lycamona
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 years
years, months or days

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

4. Sex fm 5. Color or race W
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife Jaylor Smith 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 1 1860
(Month) (Day) (Year)

8. AGE: Years 84 Months 10 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace St. Charles Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Robert Henchey
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Hammett
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alice Surawant
(b) Address 633 E. Lycamona

17. (a) Burial (b) Date thereof Nov. 20 - 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Ferry Funeral Home
(b) Address Nevasa, Missouri

19. (a) 11-22-44 (b) Fogel B. Burch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Vermon
(c) City or town Nevasa
(If outside city or town limits, write "RURAL")
(d) Street No. 633 E. Lycamona
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 18 year 1944 hour 8 minute 9 M.
21. I hereby certify that I attended the deceased from Nov-15 1944 to Nov-18 1944 that I last saw him alive on Nov-15 1944 and that death occurred on the date and hour stated above.

Immediate cause of death I don't know. I saw him on 15th. In pop - injury
Due to hip not fractured

Due to _____
Other conditions Disability
(Include pregnancy within 3 months of death)
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations no operation
Of autopsy none
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 About Nov-10th
(c) Where did injury occur? Nevasa Vermon map
(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)
Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Nevasa, Mo Date signed 11-21-44

1327

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

DEC 18 1944

RECEIVED

Health Officer No. 7

11-44-1342

Date Filled 12-5-44

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 *KP*

Registered Apprentice No.

working under my personal supervision.

Signed *R B Ferry*

Licensed Embalmer No. *1760*

P. O. Address *Nevada 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. See

Registration District No. 360

Primary Registration District No. 3076

Registrar's No. 124

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

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Nevada
(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 Sarah A Smith

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

4. Sex F 5. Color or race W 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 Jan 11 1886
(Month) (Day) (Year)

8. AGE: Years 84 Months _____ Days _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____
(Date 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 Nov Day 18 Year 1946 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above. Immediate cause of death I only saw the deceased once, at that time she gave up her body of poisoning and broke her legs. The trip was not finished.

Due to the wife quite old, and very thin
Other conditions: The fall occurred several days before I saw her.
(Include pregnancy within 3 months of death)

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of operations _____
Of 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) Auto Accident
(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 fall

23. Signature [Signature] (M. D. or other) _____
Address Nevada, Mo Date signed 2-16-46

39071