

FILED DEC 18 1944

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **319**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Hicksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Nursing Home
(If not in hospital or institution, write street number or location) **4**
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **2 months**
years, months or days

3. (a) PRINT FULL NAME **Armintha Smith**

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

4. Sex **F.** 1 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **W.**

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

7. Birth date of deceased **Dec. 11, 1861**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 11 20 hr. min.

9. Birthplace **Lemons, Mo.** 0
(City, town, or county) (State or foreign country)

10. Usual occupation **Homework**

11. Industry or business _____

MOTHER FATHER { 12. Name **Hugh Hiney**

13. Birthplace **Penn.** 1
(City, town, or county) (State or foreign country)

14. Maiden name **Sibilla Flake**

15. Birthplace **Penn** 1
(City, town, or county) (State or foreign country)

16. (a) Informant **Hugh Hiney**

(b) Address **Lemons, Mo.**

17. (a) **Burial** (b) Date thereof **12-4-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Unionville, Mo.**

18. (a) Signature of funeral director **T. J. Wagoner**

(b) Address **Unionville, Mo.**

19. (a) **12-1-44** (b) **Mrs. J. Wagoner**
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Putnam** **86**
(c) City or town **Unionville, Mo.** **1**
(If outside city or town limits, write "RURAL") **6**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **1**
year **1944** hour **3** minute **30** P. M.

21. I hereby certify that I attended the deceased from **Oct 1**, 19**44**,
to **Dec 1**, 19**44**.
that I last saw her alive on **Dec 1**, 19**44**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia** **5 hours**
Uremic collapse **4 days**

Due to **Chronic Glomerulonephritis**
Other conditions **Chronic Myocarditis**
(Include pregnancy within 3 months of death)

Major findings: **1318**
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury **3**
23. Signature **M. T. Hattenbergh** (M. D. or other) **MD**
Address **Hicksville, Mo.** Date signed **12-1-44**

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

10 69

RECEIVED

District Health Officer No. 10⁰

District File Number 12-44-2082

Date Filed DEC 15 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 Muel Husted

Licensed Embalmer No. 3304

P. O. Address Unionville 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.