

FILED FEB 7 1945

Registration District No. 124

Primary Registration District No. 5562

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Iron  
 (b) City or town Acadia Rural acadia  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: The Home for Aged Baptists  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 yrs 1 mo 9 da  
 (Specify whether years, months or days)  
 In this community 3 yrs 1 mo 2 1/2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Iron 47  
 (c) City or town Acadia Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26  
 year 1945 hour 8:45 minute A M.  
 21. I hereby certify that I attended the deceased from Dec. 28<sup>th</sup>  
 1944 to Jan. 26<sup>th</sup>, 1945  
 that I last saw h. alive on Jan. 25<sup>th</sup>  
 and that death occurred on the date and hour stated above.

Immediate cause of death: acute Bx lateral  
bronchial pneumonia  
 Due to \_\_\_\_\_  
acute naso-pharyngitis  
 Due to \_\_\_\_\_  
diabetes mellitus  
 Other conditions: degenerative  
 (Include pregnancy within 3 months of death)

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) \_\_\_\_\_  
 (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: R. E. Harland (M. D. or other)  
 Address: Linton, Mo. Date signed: Jan. 20 1945

3. (a) PRINT FULL NAME Mr. Vienna Elizabeth Smith

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife John Smith 6. (c) Age of husband or wife if alive deceased years  
 7. Birth date of deceased March 17, 1865  
 (Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business Her home

12. Name John Mouser

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

14. Maiden name Lark Meyers

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

16. (a) Informant John H. Bursney

(b) Address Linton, Mo.

17. (a) BURIAL (b) Date thereof 1-27-1945  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation M.F. GAULD MC

18. (c) Signature of funeral director GAULD

(b) Address Marquand, Mo.  
 19. (a) Jan 29 1945 (b) Madronia E. Toward  
 (Date received local registrar) (Registrar's signature)

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

700

RECEIVED

District Health Officer No. 4

District File Number 245-173

Date Filed 2-6-45

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.

*No Embalming  
John H. H. 126*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.