

FILED MAR 2 1945

Registration District No. 22

Primary Registration District No. 1000

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1709 So. 11th. St.  
(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 Jennie Shockley 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 Married

6. (b) Name of husband or wife Wm. Hampton Smith 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased July 12 1875  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	6	27	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name James M. Shockley

13. Birthplace Frazer Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cobb

15. Birthplace Frazer Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Hampton Smith

(b) Address 1709 So. 11th. St.

17. (a) Burial (b) Date thereof Feb. 12, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Wm. Hampton Smith

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) 2-12-45 (b) Wm. Hampton Smith  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1709 So. 11th. St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9  
year 1945 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2/8/45, 19\_\_\_\_, to 2/8/45, 19\_\_\_\_;  
that I last saw him alive on 2/8/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death coronary occlusion 8 hrs.

Due to Chronic myocardial infarction 1 yr.  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 9/20  
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) \_\_\_\_\_  
(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 \_\_\_\_\_

23. Signature Wm. Hampton Smith (M.D. or other) \_\_\_\_\_  
Address Kirkpatrick Bell Date signed 2/10/45

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

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(Licensed Embalmer's Statement on Reverse Side)

**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 Keith Collier  
Licensed Embalmer No. 3632  
P. O. Address St Joseph 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.**