

No. 2
1-4-41
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7320

State File No. _____

FILED FEB 24 1948
Urban

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Libertan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
In this community 2 or 3 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph A. Smith

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. 9-8-1894
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Memphis Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation land searing

11. Industry or business _____

MOTHER FATHER { 12. Name Will Smith 9

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

14. Maiden name Lucy Rudy

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

16. (a) Informant Wm. F. Deuser

(b) Address 790 No. Belvedere Memphis

17. (a) Burial (b) Date thereof 1-5-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Superston Mo

18. (a) Signature of funeral director John Albritton

(b) Address St. Keenan Mo

19. (a) 2/5/48 (b) Lucie Largent
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott
(c) City or town Libertan 10-0
(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 NO.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 2
year 1948 hour 2 minute 35 P.M.

21. I hereby certify that I attended the deceased from 12-27-48
_____ 19____ to _____ 19____

that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above. _____ 19____

Immediate cause of death _____ Duration
cerebral hemorrhage 5 day

Due to Arteriosclerosis

Due to of 2/2

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. D. Urban (M. D. or other) M.D.

Address Superston Mo Date signed 1-16-48

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

RECEIVED

District Health Office Nō

District File Number 245-23

Date Filed 2-15-45

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.

Signed

John Alenton

Licensed Embalmer No. 2941

P. O. Address *Sakramento*

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

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

Registration District No. 333 Primary Registration District No. 3074

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

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Likertown
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Joseph A. Smith

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 8
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 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 _____ Day _____
Year 1945 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 _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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) _____

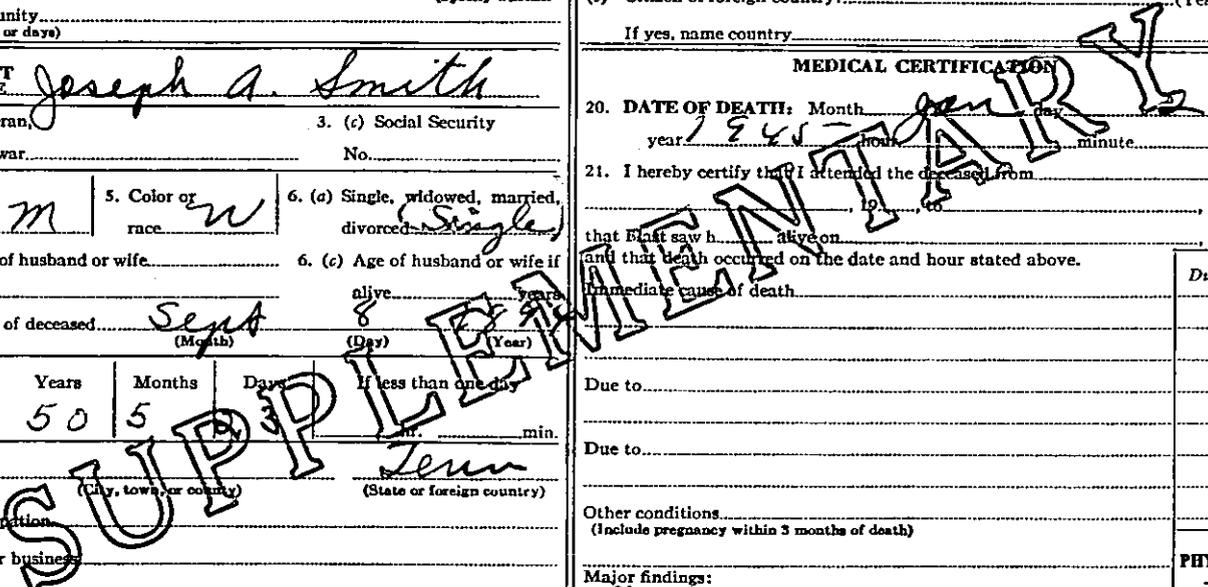
(b) Date of occurrence _____

(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 _____ (M. D. or other) _____
Address _____ Date signed _____



7320