

7. S. No. 2  
DM-9-4-41  
ev. 5-17-39  
I X29484

**FILED APR 7 1945**  
Registration District No. **47**

Primary Registration District No. **3008**

14

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

1. PLACE OF DEATH:

(a) County Galloway

(b) City or town Fullon  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
State Hospital #01 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)

In this community 8 days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Gascoyne

(c) City or town Owensville 14  
(If outside city or town limits, write "RURAL")

(d) Street No. Rural 1  
(If rural, give location)

(e) Citizen of foreign country? no 2 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Arlene Smith

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11  
year 1945 hour 4 minute 55 P.M.

21. I hereby certify that I attended the deceased from March 8th 1945 to March 11 1945; that I last saw h. er alive on March 11 1945; and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race white

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 April 10 1921  
(Month) (Day) (Year)

Immediate cause of death Myocardial Infarction

Due to Diabetes mellitus

Due to \_\_\_\_\_

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

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>11</u>	<u>1</u>	hr. _____ min. _____

9. Birthplace Gascoyne MO 11  
(City, town, or county) (State or foreign country)

10. Usual occupation none

Major findings: Of operations gud

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

12. Name Harry Smith

13. Birthplace Owensville MO 0  
(City, town, or county) (State or foreign country)

14. Maiden name Ellen White

15. Birthplace Owensville MO 0  
(City, town, or county) (State or foreign country)

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 Forrest Thomas (M. D. or other) 0  
Address Fullon MO Date signed 3/11/45

16. (a) Informant Harry Smith

(b) Address Owensville MO

17. (a) BURIAL (b) Date thereof 3-14-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OWENSVILLE MO

18. (a) Signature of funeral director W. E. S. White

(b) Address 0 W. E. S. White MO

19. (a) 3-11-1945 (b) Joace M. M. M. M.  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 9

District File Number \_\_\_\_\_

Date Filed 4-6-45

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 Me

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Melford H. Winter

Licensed Embalmer No. 3838

P. O. Address Owensville 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.