No. 2
-8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1945

Registration District No. 74

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9455

Primary Registration District No. 4136

Registrar's No. 33-13

1. PLACE OF DEATH:

(a) County Clinton

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

(c) Name of hospital or institution: 1 (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) 4 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

(c) City or town St. Joseph 11 (If outside city or town limits, write "RURAL")

(d) Street No. 2508 S. 10th 1 (If rural, give location) 7

(e) Citizen of foreign country? 1 (~~Yes or~~ No)

If yes, name country

3. (a) PRINT FULL NAME William EMMETT SMITH

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male 0

5. Color or race white

6. (a) Single, widowed, married, divorced married 1

6. (b) Name of husband or wife Rosa Smith

6. (c) Age of ~~husband~~ or wife if alive 72 years

7. Birth date of deceased Jan (Month) 27 (Day) 1863 (Year)

8. AGE: Years 82 Months 0 Days 25 If less than one day hr. min.

9. Birthplace Dennison (City, town, or county) Texas 1 (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name William Smith
13. Birthplace (City, town, or county) Tenn 1 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) " " 9 (State or foreign country)

16. (a) Informant Jennie A. Crain

(b) Address 2601 Ami Court Kansas City

17. (a) Burrise (Burial, cremation, or removal) (b) Date thereof Feb 25 (Month) (Day) (Year)

(c) Place: burial or cremation PERRIN CEMETARY

18. (a) Signature of funeral director Jas L Martin

(b) Address Plattsburg

19. (a) 2-27-45 (Date received local registrar) (b) Mrs A C Hartell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23 year 1945 hour 5 minute 0 M.

21. I hereby certify that I attended the deceased from Feb. 2, 1945 to Feb 23, 1945 that I last saw him alive on Feb. 13, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Senil and general debility

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 2

23. Signature R. W. Hayward, Pl. (M. D. or other)

Address Plattsburg Mo. Date signed 2/25/45

1085 (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 Jas L Martin

Licensed Embalmer No. 4303

P. O. Address Plattsburg

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

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

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 74 Primary Registration District No. 4136 Registrar's No. 33-13

1. PLACE OF DEATH:

(a) County Clinton

(b) City or town Plattsburg
(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)

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

3. (a) PRINT FULL NAME Wm E. 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 27 (Day) 1863 (Year)

8. AGE: Years 82 Months 0 Days 22 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations ADDITIONAL
SUPPLEMENTARY
Of autopsy INFORMATION
REQUESTED

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

9455