DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 4 1945

Registration District No. 325

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10767

Primary Registration District No. 4477

Registrar's No. 15

1. PLACE OF DEATH:

(a) County: Schuyler

(b) City or town: Downing (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 years, months or days)

In this community: 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Schuyler

(c) City or town: Downing (If outside city or town limits, write "RURAL") R

(d) Street No. — (If rural, give location) R

(e) Citizen of foreign country? — R (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME: Samuel Green Smoot

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: Ella Smoot

6. (c) Age of husband or wife if alive: 77 years

7. Birth date of deceased: June (Month) 14 (Day) 1862 (Year)

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

9. Birthplace: Scotland Co. (City, town, or county) Mo (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: Joseph Smoot

FATHER 13. Birthplace: Va (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: —

MOTHER 15. Birthplace: — (City, town, or county) (State or foreign country)

16. (a) Informant: Ella Smoot

(b) Address: Downing Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 24 1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Campground

18. (a) Signature of funeral director: Loyd Moore

(b) Address: Downing Mo.

19. (a) 3-1-1945 (Date received local registrar) (b) A. A. Justice (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1945 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 20, 1945 to Feb 22, 1945 that I last saw him alive on Feb 22, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: General Debility / Heart Failure

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations:

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: H. E. Gerwig (M. D.)

Address: Downing Mo. Date signed: Feb 28

1278 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No.
District File Number 4-45-3
Date Filed APR 3 1945

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 Loyd Moore

Licensed Embalmer No. 3151

P. O. Address Downing m

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.

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. March

Registration District No. 325 Primary Registration District No. 4476 Registrar's No. 15

1. PLACE OF DEATH:

(a) County Gallant Schuyler

(b) City or town Downing
(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 Samuel G. Smoot

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 June (Month) 14 (Day) 1886 (Year)

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

9. Birthplace (City, town, or county) Mo (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 22
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

Due to Myocarditis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

10767