

FILED MAR 16 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10783

Registration District No. 336

Primary Registration District No. 4494

Registrar's No.

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Winnona Mo
(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 MO (b) County Shannon
(c) City or town Winnona Mo
(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 Nettie B Smith
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 2
year 1945 hour 8 minute 0 M.
21. I hereby certify that I attended the deceased from Jan 1
1945 to Mar 2 1945
that I last saw her alive on Mar -2- 1945
and that death occurred on the date and hour stated above.

4. Sex 2 1. Color or race A
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife S.H. Smith
6. (c) Age of husband or wife if alive 89 years
7. Birth date of deceased Aug 18 1870
(Month) (Day) (Year)

Immediate cause of death Acute Dilatation of Stomach
Due to Influenza Pneumonia
Due to _____

8. AGE: Years Months Days If less than one day
74 6 14 _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death)
Major findings: 33
Of operations _____
Of autopsy _____

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

10. Usual occupation Wife

11. Industry or business _____

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

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

16. (a) Informant Smith S.H.

(b) Address Winnona Mo
17. (a) Burial (b) Date thereof 3-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Winnona Chapel

18. (a) Signature of funeral director Lucretia

(b) Address Van Buren Mo

19. (a) 3-2-45 (b) Frank Hyde Mo
(Date received local registrar) (Registrar's signature)

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 Frank Hyde (M. D. or other)
Address Winnona Date signed 3-2-45

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

MOTHER FATHER

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

744

RECEIVED

District Health Officer No. 5,

District File Number 345153

Date Filed 3, 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.....

Licensed Embalmer No.....

P. O. Address.....

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.