G. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 11 1945

Registration District No. 1535

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13707

Primary Registration District No. 5579

Registrar's No. 5

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: Alba
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Alba 1
(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: 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jasper 47
(c) City or town: Alba 0
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country: - - -

3. (a) PRINT FULL NAME: David Ray Smith
3. (b) If veteran, name war: No
3. (c) Social Security No. 512-07-3092
4. Sex: Male ()
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Lavona Smith
6. (c) Age of husband or wife if alive: 54 years
7. Birth date of deceased: January (Month) 3 (Day) 1885 (Year)

8. AGE: Years 60 | Months 3 | Days 14 | If less than one day: ..... hr. ..... min.

9. Birthplace: Alba (City, town, or county) Missouri 1 (State or foreign country)
10. Usual occupation: Mgr. Service Mine Supply
11. Industry or business: Picher, Okla.

FATHER
12. Name: Stephen Smith
13. Birthplace: Unknown (City, town, or county) Ohio 1 (State or foreign country)

MOTHER
14. Maiden name: Rahama Groom
15. Birthplace: Warren Co. (City, town, or county) Iowa 1 (State or foreign country)

16. (a) Informant: Mrs. Lavona Smith
(b) Address: Alba, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 22 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Friends Cemetery
18. (a) Signature of funeral director: Knell Mortuary
(b) Address: Carthage, Missouri
19. (a) Apr. 22, 1945 (Date received local registrar) (b) Mrs. Lillie Lagle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 17 year 1945 hour 11 minute 40 P. M.
21. I hereby certify that I attended the deceased from Apr 17 45, 19..., to Apr 17 45, 19..., that I last saw him alive on Apr 17 45, 19..., and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Corornary Occlusion	
Due to:	
Due to:	
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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: W. B. Dogan (M. D. or other)
Address: Neck City, Mo. Date signed: 4-19-45

1180

(Licensed Embalmer's Statement on Reverse Side)

45-4-366

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 Emm L Steel

Licensed Embalmer No. 391

P. O. Address Carthage

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.