. S. No. 2
OM—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16456

FILED JUN 14 1945

Registration District No. 1

Primary Registration District No. 3007

Registrar's No. 152

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Poplar Bluff, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Poplar Bluff Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME J. C. Smith
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
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 Dec. (Month) 19 (Day) 1928 (Year)

8. AGE: Years 15 Months 5 Days 6 If less than one day hr. min.

9. Birthplace (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Student
11. Industry or business
FATHER
12. Name John Smith
13. Birthplace (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Clay Byrd
15. Birthplace (City, town, or county) Indiana (State or foreign country)
16. (a) Informant John Smith
(b) Address Corning, Arkansas
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation Corning Cem.
18. (a) Signature of funeral director W. H. Toby
(b) Address Corning, Arkansas
19. (a) 5/29/45 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25, 1945
year 6 hour 55 minute a M.
21. I hereby certify that I attended the deceased from May 13, 1945, to May 25, 1945, that I last saw him alive on May 25, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation
Due to Acute Cardiac failure
Due to Acute Myelogenous Leukemia
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations None
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 C. D. Markel M.D. (M. D. or other)
Address Poplar Bluff Mo. Date signed 5-25-45

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED
District Health Office No. 2
District File Number 645-828
Date Filed 6-12-45

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 Delus Johnson

Licensed Embalmer No. 4271 and 680

P. O. Address Corning Calif.

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.