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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 28 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20468

Registration District No. 141 Primary Registration District No. 5556 Registrar's No. 14

1. PLACE OF DEATH:

(a) County Howell

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

(c) Name of hospital or institution: 1 Spring Creek Twp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 30 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howell

(c) City or town Cureall 46
(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 Jas. Melton 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 Gertie Smith 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Nov 2 (Month) (Day) (Year)

8. AGE: Years 56 Months Days If less than one day ..... hr. ..... min.

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

10. Usual occupation Minister

11. Industry or business ✓

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

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

16. (a) Informant Mrs. J. M. Smith
(b) Address Cureall, Mo.

17. (a) B (Burial, cremation, or removal) (b) Date thereof 6/9-45 (Month) (Day) (Year)
(c) Place: burial or cremation Cheap Springs

18. (a) Signature of funeral director Robert Ns
(b) Address West Plains, Mo.

19. (a) 6/20-45 (Date received local registrar) (b) Earl Hailey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 7
year 1945 hour 12 minute 50 P. M.

21. I hereby certify that I attended the deceased from May 7 1945 to May 29 1945
that I last saw him alive on May 29 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Heart Disease	
Due to	
Due to 95c2	
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 H. Hogan M.D. (M. D. or other)
Address West Plains Mo. June 17-45 Date signed

112.5 (Licensed Embalmer's Statement on Reverse Side)

Hogan

RECEIVED
District Health Officer No. 5
District File Number 645.304
Date Filed 6.27.45

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 D D Roberts

Licensed Embalmer No. 3432

P. O. Address West Plains, Mo

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.