

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED SEP 8 1945 STANDARD CERTIFICATE OF DEATH

27713

State File No.

Registration District No. 168

Primary Registration District No. 5611

Registrar's No.

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Post Oak Twp.
(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 lyr.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson ⁵¹

(c) City or town Rural Route, Chilhowee ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) ⁰

(e) Citizen of foreign country? no (Yes or No) ⁰

If yes, name country _____

3. (a) PRINT FULL NAME Robert Lawson Smith

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Ena Smith

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

7. Birth date of deceased Oct. 23 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 9 27 hr. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19
year 1945 hour 06 minute 00 P.M.

21. I hereby certify that I attended the deceased from Aug. 19, 1945, to Aug 19, 1945;
that I last saw him alive on Aug. 18, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration

Due to _____

Due to _____

Other conditions Diabetes
(include pregnancy within 3 months of death)

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

10. Usual occupation Farmer

11. Industry or business Same

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Samantha Lawson

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

16. (a) Informant Mrs. Florence Hilligoss

(b) Address Marion, Indiana

17. (a) Burial (b) Date thereof 8/21/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Providence Ceme.

18. (a) Signature of funeral director J. W. Cook

(b) Address Chilhowee, Mo.

19. (a) Aug 21, 1945 (b) Nellie H. Bradley
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations _____

Of autopsy 61

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. N. Robinson (M. D. or other) ^{2 20.}

Address Chilhowee Date signed 8/29/45

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

1393

(Licensed Embalmer's Statement on Reverse Side)

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.....

J. W. Cook

Licensed Embalmer No. *4335*

P. O. Address. *Chillicothe, 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.