

FILED AUG 20 1945 STANDARD CERTIFICATE OF DEATH

State File No. 28133

Registration District No. 270

Primary Registration District No. 3050

Registrar's No. 67

1. PLACE OF DEATH:

(a) County Remiscot  
(b) City or town Caruthersville  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 Months  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Shirley Gean Smith

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 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 Nov 3 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
8 20 hr. min.

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

10. Usual occupation None

11. Industry or business None

12. Name Wright Smith

13. Birthplace Tiptonville, Tenn  
(City, town, or county) (State or foreign country)

14. Maiden name Mildred Looney

15. Birthplace Walnut Ridge, Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mildred Smith

(b) Address Caruthersville, Mo.

17. (a) Burial (b) Date thereof 7-25, 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hayti, Mo.

18. (a) Signature of funeral director J.L. German

(b) Address Steele, Mo.

19. (a) Aug 13 1945 (b) Jessie N. Markey  
(Date of final registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Remiscot  
(c) City or town Caruthersville  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 23 day July  
year 1945 hour 11 minute 5

21. I hereby certify that I attended the deceased from 7-23-45  
to 7/23/45, 19\_\_\_\_;  
that I last saw h. ER alive on 7/23/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Infantile Parotid 3 Days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations 36  
Of autopsy \_\_\_\_\_

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) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

7-45-151

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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. R. Small

Licensed Embalmer No. 3100

P. O. Address Blytheville

**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.