V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30180

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 999

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Days (Specify whether
In this community 20 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Buchanan
(c) City or town St. Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 907 Mitchell Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Albert Walter Smith
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Stella Smith
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased April (Month) 18 (Day) 1879 (Year)

8. AGE: Years 66 Months 7 Days 29 If less than one day hr. min.

9. Birthplace Lincoln County (City, town, or county) Kentucky (State or foreign country)
10. Usual occupation Retired Stewart
11. Industry or business State Hospital # 2

FATHER
12. Name Newton J. Smith
13. Birthplace Unknown (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Patsey Chilton
15. Birthplace Unknown (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Mrs. A. W. Smith
(b) Address 907 Mitchell Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep't. 19, 45 (Month) (Day) (Year)
(c) Place: burial or cremation Stanberry, Missouri.
18. (a) Signature of funeral director Herman Wm. Fedenfader
(b) Address 1802 Union St. St. Joseph, Mo.
19. (a) Sep't. 17, 45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep't. day 17 year 1945 hour 2 minute 45 A.M.
21. I hereby certify that I attended the deceased from Mar. 15, 1944 19 , to Sept. 17 , 1945; that I last saw him alive on Sept. 16, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	5 days
Due to Arteriosclerosis	
Due to Hypertension	Over 3 yrs
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 Lexton Smith (M. D. or other) Mgr
Address 218 N. 7th St. Joseph, Mo. Date signed 9-17-45

1428

(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~~ Elmer Thomas, Registered Apprentice No. ....., working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St Joseph 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.