No. 2
-1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED NOV 2 1945

33806

State File No.

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 153

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution:
O'REILLY GENERAL HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 106 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield, 2
(If outside city or town limits, write "RURAL")

(d) Street No. 1924 N. Roosevelt 6
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME CLEO MARIE SMITH

3. (b) If veteran, name war None

3. (c) Social Security No. UNK.

4. Sex Female /

5. Color or race White

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

6. (b) Name of husband or wife James Wilbur Smith

6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased September (Month) 23 (Day) 1904 (Year)

8. AGE: Years ✓ 40 Months 5 Days 0 If less than one day hr. min.

9. Birthplace Granite, ~~Okla.~~ (City, town, or county) Okla. / (State or foreign country)

10. Usual occupation Waitress

11. Industry or business

FATHER
12. Name Jack Baker
13. Birthplace UNK. (City, town, or county) UNK. 9 (State or foreign country)

MOTHER
14. Maiden name Dora Wood
15. Birthplace ~~Texas~~ UNK. (City, town, or county) Texas / (State or foreign country)

16. (a) Informant Mrs. C. C. Farmer
(b) Address Springfield Mo R#10 B175

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 26 Feb. 1945 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director [illegible]
(b) Address Springfield Mo

19. (a) 2-24-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

987

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 23 year 1945 hour 11 minute 50 A. M.

21. I hereby certify that I attended the deceased from 1 February 1945 to 23 February 1945 that I last saw her alive on 23 February 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	36 Hrs.
Due to	
Due to	
Other conditions Carcinoma of stomach (Include pregnancy within 3 months of death)	

Major findings: Of operations Extensive adhesions throughout adbomen. Obstructive mass pylorus adherent to liver. Carcinomatosis.
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 K. R. Coffey Major, M.C. (M. D. or other)
Address O'Reilly Gen Hospital Date signed 2/23/45

(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 Ogle Stone Jr.

Licensed Embalmer No. 4124

P. O. Address Springfield Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

CORRECTED COPY

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. _____

State of MISSOURI

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town SPRINGFIELD (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: O'REILLY GENERAL HOSPITAL (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 108 days (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield (If outside city or town limits, write RURAL)
(d) Street No. 1924 N. Roosevelt (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) FULL NAME CLEO MARIE SMITH
3. (b) If veteran, name war _____
3. (c) Social Security No. _____
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James Wilbur Smith
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased September (Month) 23, (Day) 1904 (Year)

8. AGE: Years	Months	Days	If less than one day
40	5		hr. min.

9. Birthplace Granite (City, town, or county) Oklahoma (State or foreign country)
10. Usual occupation Waitress
11. Industry or business _____

FATHER
12. Name Jack Baker
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name Dora Wood
15. Birthplace _____ (City, town, or county) Texas (State or foreign country)

16. (a) Informant's own signature /s/ Mrs. C. C. Farmer
(b) Address Springfield, Mo., R. #10, Box 175
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1945 (Month) (Day) (Year)
(c) Place; burial or cremation Springfield, Mo.
18. (a) Signature of funeral director /s/ J. W. Klingner & Co.,
(b) Address Springfield, Mo.
19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month February day 23 year 1945 hour 11 minute 50 A.M.
21. I hereby certify that I attended the deceased from 1 February, 1945, to 23 February, 1945; that I last saw her alive on 23 February, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia, cause undetermined	36 hrs.
Due to	
Due to	
Other conditions: Carcinoma simplex, of stomach. (Include pregnancy within 3 months of death)	
Major findings: Of operations: Extensive adhesions throughout abdomen, obstructive mass, pylorus, adherent to liver, carcinomatosis. Of autopsy: Findings as above.	

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 R. K. Caffey O. M. D. or other MC
Address O'Reilly G.H., Springfield, Mo Date signed 7/14/45

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493

338806