

FILED NOV 8 1945

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 160

1. PLACE OF DEATH:

(a) County Saline
Marshall
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Fitzgibbons Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days
(Specify whether _____)
In this community 6 Months
(years, months or days)

3. (a) PRINT FULL NAME Chester B. Smith

3. (b) If veteran, name war _____ 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 Orlinda Smith 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased May 12th, 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 5 14 hr. _____ min.

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

10. Usual occupation Retired farmer

11. Industry or business _____

12. Name E. B. Smith
13. Birthplace Ill. (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs C. B. Smith
(b) Address Blackwater, Mo.

17. (a) Burial (b) Date thereof: Oct. 28, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleton City, Mo.

18. (a) Signature of funeral director Campbell Rumi
(b) Address Marshall, Mo.

19. (a) Nov. 1-45 (b) Mrs T. O. Burkholder
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper 27
(c) City or town Blackwater 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26
year 1945 hour 9 minute 40 a.m.

21. I hereby certify that I attended the deceased from Oct. 24
1945, 19____, to Oct. 26, 1945
that I last saw him alive on Oct. 26, 1945, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Strangulated Femoral hernia
Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy yes

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 P. L. Lawless (M. D. or other)
Address Marshall Mo Date signed 10-26-45

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

7
1
2

1215

MAR 18 1947

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-8-47

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 _____

R. W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall, 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.