

S. No. 2
M-9-4-41
Ev. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILED NOV 30 1945 STANDARD CERTIFICATE OF DEATH

36492

State File No.

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Rocksville
(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 6 years (Specify whether years, months or days)
In this community 6 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Adair 999
(c) City or town Bloomfield 13
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Christina T Smallwood

3. (b) If veteran, name war v 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife A J Smallwood 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased Sept 30 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 0 Days 16 If less than one day hr. min.

9. Birthplace Fulton Co Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name Anthony Gaer

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

14. Maiden name Mary Miller

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

16. (a) Informant Maudie Smallwood
(b) Address Porterville Mo

17. (a) burial (b) Date thereof 10-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sagebrush La

18. (a) Signature of funeral director R P Wagner
(b) Address Bloomfield Iowa

19. (a) 10-16-45 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16 year 1945 hour 6:30 minute a M.

21. I hereby certify that I attended the deceased from 1942 to Oct 16, 1945
that I last saw her alive on Oct 16, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: hypertension of uterus with metastasis to bladder & bowels

Duration 5 yrs

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

Major findings: Of operations 48%
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? _____

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

23. Signature R P Wagner (M. D. or other) MD
Address Kimberly Mo Date signed 10-16-45

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

33

76 - 10-1845 -
30-9-1825 -
16-8-70

10001 M. L. Edgerton

RECEIVED

District Health Officer No. 10

District File Number 11-45-2795

Date Filed NOV-27-1945

M.W.

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 *[Signature]*
Licensed Embalmer No. 3250
P. O. Address Bloomfield, Iowa

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.