V. S. No. 2
50M—5-42
Rev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 14 1946

State File No. 41307

Registration District No. 132 Primary Registration District No. 5481 Registrar's No.

40
0
0

1. PLACE OF DEATH:

(a) County Grundy

(b) City or town Laredo - Rural - Wilson Twp (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 (Specify whether In this community 2 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mercer 65

(c) City or town Half Rock. 0 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? No. 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Cora Jane Smiley

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 Andrew J. Smiley 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased August (Month) 9 (Day) 1868 (Year)

8. AGE: Years 77 Months 3 Days 19 If less than one day hr. min.

9. Birthplace Half Rock (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John M Gariott
13. Birthplace Not Known (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Mary B Cochorn
15. Birthplace Tenn. (City, town, or county) / (State or foreign country)

16. (a) Informant [illegible]
(b) Address 23 [illegible] Dr St Louis

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/ 1 45 (Month) (Day) (Year)
(c) Place: burial or cremation Half Rock

18. (a) Signature of funeral director E. J. Robertson Funeral Home
(b) Address Laredo Mo.

19. (a) 12-1-45 (Date received local registrar) (b) Irene Tarr (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 28 year 45 hour 2 minute 35 P.M.

21. I hereby certify that I attended the deceased from Oct, 1945 to Nov 28, 1945 that I last saw her alive on 11 28, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death End cardiac

Due to

Due to Cerebral Hemorrhage

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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? C S Thomas MD. (Specify type of place)

While at work? (e) Means of injury

23. Signature C S Thomas (M. D. or other) 0

Address Laredo Mo. Date signed 11 28 45

1451

(Licensed Embalmer's Statement on Reverse Side)

JAN 16 1945

RECEIVED
District Health Officer No. 11,
District File Number.....
Date Filed.....

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 John M Robertson

Licensed Embalmer No. 4388

P. O. Address Laredo 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.