

FILED JAN 5 1946

State File No. \_\_\_\_\_

Registration District No. 155

Primary Registration District No. 3127

Registrar's No. 138

1. PLACE OF DEATH:

(a) County Jasper  
 (b) City or town Waltham City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1305 W. SIXTH  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community life years, months or days

3. (a) PRINT FULL NAME Paul W Smith  
 3. (b) If veteran, name war XX  
 3. (c) Social Security No. XX

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Leahann Smith 6. (c) Age of husband or wife if alive 59 years  
 7. Birth date of deceased March 30 1886  
 (Month) (Day) (Year)

8. AGE: Years 59 Months 8 Days 22 hr. \_\_\_\_\_ min. \_\_\_\_\_  
 If less than one day

9. Birthplace Orange Missouri (City, town, or county) (State or foreign country)  
 10. Usual occupation Cool Dealer  
 11. Industry or business Coal Dealer  
 12. Name Paul W Smith  
 13. Birthplace Stone County, Mo. (City, town, or county) (State or foreign country)  
 14. Maiden name Sarah Stuebel  
 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Ms Paul Smith  
 (b) Address Waltham City, Mo.  
 17. (a) Burial (b) Date thereof Dec 24 45  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Heaven Care  
 18. (a) Signature of funeral director Waltham City  
 (b) Address \_\_\_\_\_  
 19. (a) 12/23/1945 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
 (c) City or town Waltham City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1305 Waltham  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1945 hour 4:15 minute 0 M.  
 21. I hereby certify that I attended the deceased from 12-13 1945 to 12-22 1945  
 that I last saw him alive on 12-22 and that death occurred on the date and hour stated above.

Immediate cause of death Influenza  
 Duration \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 NATIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 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) (or) Means of injury \_\_\_\_\_  
 Signature Ms Paul Smith Date signed 12-23/45  
 Address \_\_\_\_\_

**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 myself

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City

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

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 15-5

Primary Registration District No. 3127

Registrar's No. 138

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Webb City  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Paul A. Smith

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 31 1944  
(Month) (Day) (Year)

8. AGE: Years 5-9 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 22  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_, \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

41518