

FILED FEB 7 1946

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

Registration District No. 115

Primary Registration District No. 4187

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Union mo  
(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 50 years years, months or days

3. (a) PRINT FULL NAME Mary Smith  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Henry Smith 6. (c) Age of husband or wife if alive Dead years  
7. Birth date of deceased: 16 1877 (Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days 20 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation House wife

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

MOTHER FATHER { 12. Name Frank Hummel 11  
13. Birthplace Germany (State or foreign country)  
14. Maiden name Elizabeth Holmgren  
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Ben Smith 1  
(b) Address Union mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (Month) (Day) (Year)

(c) Place: burial or cremation Union mo

18. (a) Signature of funeral director Osby & Sons

(b) Address St Clair mo

19. (a) 1-7-46 (Date received local registrar) (b) F. J. Cooper - Ek. 1 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36  
(c) City or town Union mo 5  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 1 day 5 year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 12-29-45 1945 to 1-5-46 1946 that I last saw him ok alive on 1-4 1946 and that death occurred on the date and hour stated above.

Immediate cause of death thromboplexy

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

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

Major findings: Of operations (g)  
Of autopsy \_\_\_\_\_

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 Dr. M. J. J. J. (M. D. or other) Dr. J.  
Address Union mo Date signed 1-7-46

Duration 1 wk  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed 2-6-46

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. M. Lewis  
Licensed Embalmer No. 3601  
P. O. Address St. Clair, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 115

Primary Registration District No. 4187

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Union  
(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Mary Smith

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

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

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

7. Birth date of deceased Jan (Month) 1922 (Year)

8. AGE: Years 69 Months 11 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

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

MOTHER FATHER

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

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

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

(b) Address \_\_\_\_\_

19. (a) Jan 7 1946 (b) F. T. O'Brien - E. F. C. (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 \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 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 \_\_\_\_\_

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 \_\_\_\_\_

SUPPLEMENTARY

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

583

2633