

S. No. 2
M-8-43
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9015

State File No.

FILED APR 6 1946
Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 25

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
7943

1. PLACE OF DEATH:
Franklin

(a) County Washington

(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days
(Specify whether years, months or days)

In this community 2 Days
years, months or days

3. (a) PRINT FULL NAME Berth Ellen Smith

3. (b) If veteran, name war no

3. (c) Social Security No. none

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

6. (b) Name of husband or wife William A. Smith 6. (c) Age of husband or wife if alive 31 years (Year) 1900

7. Birth date of deceased Aug. (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>5</u>	<u>27</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Ike Calvin

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

14. Maiden name Josephine Laretto

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

16. (a) Informant W. H. Smith

(b) Address Kilgore, Texas

17. (a) Burial (b) Date thereof March 2, 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pacific Mo.

18. (a) Signature of funeral director John S. Tobias

(b) Address Pacific Mo.

19. (a) 3/12/46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County X 107

(c) City or town Kilgore
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? None (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 28
year 1946 hour 9:30 minute 00 A.M.

21. I hereby certify that I attended the deceased from Feb 28
46, 1946 to Feb 28, 1946
that I last saw her alive on Feb 28, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 46

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 [Signature] (M. D. or other)

Address [Address] Date signed 3/12/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

99

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 4-5-86

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

August H. Burns Jr.

Licensed Embalmer No. 4338

P. O. Address. Spiceland, 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.