DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED APR 15 1946

State File No. 9045

Registration District No. 120 Primary Registration District No. 4194 Registrar's No. 33

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

1. PLACE OF DEATH:

(a) County Gentry

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

(c) Name of hospital or institution: 1 (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Gentry 38

(c) City or town Albany (If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charles Edgar Smith

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race W.

6. (a) Single, widowed, married or divorced Married 1

6. (b) Name of husband or wife Pauline Gallagher

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased November 11-1872 ~~1873~~ ~~1874~~ 1872 (Month) (Day)

8. AGE: Years 73 Months 4 Days 6 If less than one day hr. min.

9. Birthplace Wood River (City, town, or county) Neb. 1 (State or foreign country)

10. Usual occupation retired railroad agent

11. Industry or business

MOTHER FATHER

12. Name Marion V. Smith

13. Birthplace Crown Point (City, town, or county) Ind 1 (State or foreign country)

14. Maiden name Mary A. Anderson

15. Birthplace Crown Point (City, town, or county) Ind 1 (State or foreign country)

16. (a) Informant Mrs Charles Smith

(b) Address Albany Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/46 (Month) (Day) (Year)

(c) Place: burial or cremation Grandview

18. (a) Signature of funeral director C. Clifford Burke

(b) Address Albany Mo

19. March 23-1946 (Date received local registrar) (b) Homer McMahan (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 17 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from June, 1945, to 3-17, 1946, that I last saw him alive on 3-17-, 1946, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of lungs	3 mos.
Due to " of Gall-bladder	1 year.
Due to Gall-stones? SUPPLEMENTARY INFORMATION REQUESTED	
Other conditions (Include pregnancy within 3 months of death): Gall-stones worked out thru	
Major findings: Of operations abdomin wall many years	
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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Frank H. Rose (M. D. or other) M. D.

Address Albany, Mo Date signed 3-18-46

103

(Licensed Embalmer's Statement on Reverse Side)

SEP 19 1957

DISTRICT HEALTH OFFICE
Cameron, Mo.

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

Signed ..... Clifford Brooks .....

Licensed Embalmer No. 3329

P. O. Address ..... Albany 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.

No. 2B
3-45
X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April 33

Registration District No. 120 Primary Registration District No. 4194 Registrar's No.

1. PLACE OF DEATH:

(a) County Gentry (b) City or town Albany
(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 years, months or days) In this community

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

3. (a) PRINT FULL NAME Charles E. 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
7. Birth date of deceased Nov 11 (Month) (Day) (Year)
8. AGE: Years 73 Months Days If less than one day hr. min.
9. Birthplace (City, town or county) Nebr (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 11 year 1926 hour a.m. minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to ca. gall-bladder	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION RECEIVED

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

29273

9045