

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 27 1946

Registration District No. 25

Primary Registration District No. 4387 5877

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Alton Piney Twp. Rural
(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 15 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 95

(c) City or town Alton (Rural)
(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 William Edward Smith

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Alice E. Nicholson

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

7. Birth date of deceased June 1 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 4
If less than one day hr. _____ min. _____

9. Birthplace Vermillion County Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Jacob C. Smith

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

14. Maiden name Eliza J. Lafever

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

16. (a) Informant E. Smith

(b) Address Alton Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-46
(Month) (Day) (Year)

(c) Place: burial or cremation Smith Cemetery

18. (a) Signature of funeral director Geo. Carr

(b) Address Thayer, Mo.

19. (a) 3-16-46 (Date received local registrar) (b) Mrs. W. C. Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 5
year 1946 hour 8 minute 00 A. M.

21. I hereby certify that I attended the deceased from _____, 1946, to _____, 1946.

that I last saw him in alive on Jan 15 and that death occurred on the date and hour stated above. Jan 5 1946

Immediate cause of death Acute pneumonia of lungs & general debility

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) Where and how it occurred _____
(City or town) (County) (State)

(c) _____

(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 W. C. Johnson (M. D. or Ch. D.)
Address Thayer, Mo. Date signed 2-10-46

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

5-43
17-39
X36871

RECEIVED

District Health Officer No. 5,

District File Number 346266

Date Filed 3. 28. - 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 Seaf

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

Signed Leo Carr

Licensed Embalmer No. 2852

P. O. Address Hayes St

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. April
Registrar's No. _____

Registration District No. 255

Primary Registration District No. 58771

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Piney Bluff
(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 William 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 wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 1
(Month) (Day) (Year)

8. AGE: Years 72 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 _____

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) _____ (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) H-1-46 (b) mew Johnson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Oregon

(c) City or town Rural
(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 _____ Day _____
Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ 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 _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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 _____

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

SUPPLEMENTARY

22201