

FILED APR 8 1946
Registration District No. 338

Primary Registration District No. 4501

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard

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

(c) Name of hospital or institution: None
(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 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

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

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

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

If yes, name country _____

3. (a) PRINT FULL NAME CLYDE L. SMITH

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Tina Smith 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Jan. 5, 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 2 _____ hr. _____ min.

9. Birthplace Ozark Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation Hospital Attendant

11. Industry or business _____

MOTHER FATHER { 12. Name Clyde Smith

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

14. Maiden name Not known

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Tina Smith

(b) Address Bloomfield, Mo.

17. (a) Burial (b) Date thereof Mar. 7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomfield cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) 3-13-46 (b) Rose Webber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th
year 1946 hour 8:30 minute _____ A. M.

21. I hereby certify that I attended the deceased from Feb 1, 1946, to March 5, 1946, that I last saw him alive on March 5, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Edema of the lungs
Due to Chronic myocarditis

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

Major findings:
Of operations None performed
Of autopsy None performed

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 J. H. Harris (M. D. or other) MO
Address Bloomfield Mo. Date signed 3-19-46

Duration 1 day
10 yrs
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10001

RECEIVED

District Health Office No. 2,

District File Number 446-474

Date Filed 4-5-46

APR 26 1946

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.

Signature Stan B. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.