

FILED SEP 3 1946

Registration District No. 777

Primary Registration District No. 4267

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Odessa  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
206 West Dryden St. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 60 yr.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Johr Edgar Smith

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

4. Sex Male  
5. Color or race white  
6. (a) Single, widowed, married, divorced Married  
6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased Nov. 4 1874  
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 28  
If less than one day hr. min.

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

10. Usual occupation Farmer - Retired

11. Industry or business

12. Name W. A. Smith  
13. Birthplace Kingsville Mo.  
14. Maiden name Julia Rose Filler  
15. Birthplace Rowden Co. Va.

16. (a) Informant Mrs. Wilbert Fretjen  
(b) Address Odessa Mo.  
17. (a) Burial (b) Date thereof Aug 5 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Odessa Cem.

18. (a) Signature of funeral director Blinn Home  
(b) Address Odessa Mo.

19. (a) August 2 1946 (b) Letta Blinn  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 34  
(c) City or town Odessa 4  
(If outside city or town limits, write "RURAL")  
(d) Street No. 206 West Dryden 0  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No) 0  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7  
year 1946 - hour 2 minute 6 P.M.

21. I hereby certify that I attended the deceased from May 30 1946 to Aug 2 1946  
that I last saw him alive on Aug 2 1946  
and that death occurred on the date and hour stated above  
Immediate cause of death: Uremia of Bladder & Prostate  
Duration

Due to  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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 R. J. Choholly (M. D. number)  
Address Odessa Mo. Date signed 8/5/46

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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. 8, 29

District File Number .....

Date Filed 8-31-46 .....

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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 *Horace Blunice* .....

Licensed Embalmer No. *2788* .....

P. O. Address *Odessa 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. Sept

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

Registration District No. 111

Primary Registration District No. 4-267

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Odessa  
(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

John 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. 4 (Month) (Day) (Year)

8. AGE: Years 71 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) \_\_\_\_\_ (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) \_\_\_\_\_ (b) \_\_\_\_\_ (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 \_\_\_\_\_ Day \_\_\_\_\_  
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) \_\_\_\_\_

Due to \_\_\_\_\_ Primary Cell Cancer of Prostate \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_ 5/6

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) \_\_\_\_\_ (Means of injury)  
23. Signature R. C. Schaefer (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

266440

1.000

1.000

22

27601