

FILED DEC 11 1946

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 408

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: South East MO. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 6 days (Specify whether years, months or days)
 In this community. 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Gir. 16
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 2 miles east of Jackson Mo.
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Dora May Smith

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Ora A Smith 6. (c) Age of husband or wife if alive 60 years
 7. Birth date of deceased: Oct. 1 1893
(Month) (Day) (Year)

8. AGE: Years 53 Months 1 Days 29 If less than one day hr. min.

9. Birthplace Bollinger County MO.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Frank Williams
 13. Birthplace Bollinger County MO.
(City, town, or county) (State or foreign country)
 14. Maiden name Delian Boswell
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ora A Smith
 (b) Address Jackson Mo.
 17. (a) Burial (b) Date thereof 12-2-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Russell Heights Cem.

18. (a) Signature of funeral director Wilson Staller
 (b) Address Jackson Mo.
 19. (a) 12-30-1946 (b) G. G. Summers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 30
 year 1946 hour 4 minute PM M.

21. I hereby certify that I attended the deceased from Nov 19 1946 to Nov 28 1946
 that I last saw h. er alive on Nov 28 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 5 min
 Due to _____
 Due to _____
 Other conditions Fracture of femur 5 days
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 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 W. Ruff (M. D. or other) MD
 Address Jackson Mo. Date signed 12/3/46

MOTHER FATHER

4 3/4

RECEIVED

Health Officer No. 4
License Number 1246-298
Date 12-9-46

DEC 12 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.

Signed Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jacksonville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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Registration District No. *53*

Primary Registration District No. *3010*

Registrar's No. *408*

1. PLACE OF DEATH:

(a) County *Cape Girardeau*
(b) City or town *Cape Girardeau*
(If outside city or town limits, write 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 _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME *Dora May Smith*

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

4. Sex *F* 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 _____ years

7. Birth date of deceased *Oct* (Month) *2* (Day) *1906* (Year)

8. AGE: Years *53* Months _____ Days _____ (Unless than one day) hr. _____ min. _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) *MO*

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

13. (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 _____ Year *1946* Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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) *Accident* ✓

(b) Date of occurrence *Nov 26 1946* ✓

(c) Where did injury occur? *Cape Gir MO* ✓
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *at her home* ✓

While at work? *Yes* (Specify type of place) (e) Means of injury *fall* ✓

23. Signature *T.E. Ruff* (M. D. or other) *MD*

Address *Jackson MO* Date signed *1-17-47*

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAY BE PERMANENT RECORD

35138

30316