

No. 2
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FILED JAN 20 1947

State File No.

Registration District No. 44

Primary Registration District No. 5153

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Caldwell
(b) City or town New York Imp. Rural
(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
In this community 7 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Caldwell
(c) City or town Braymer
(d) Street No.
(e) Citizen of foreign country? No
If yes, name country

3. (a) PRINT FULL NAME Eloy Mathias 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 Married

6. (b) Name of husband or wife Ida May Smith
6. (c) Age of husband or wife if alive 76 years

7. Birth date of decease May 12 1857
(Month) (Day) (Year)

8. AGE: Years 89 Months 7 Days 18
If less than one day hr. min.

9. Birthplace De Graff Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

12. Name Wm Smith

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

14. Maiden name Not known
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Nathan Evans

(b) Address Hamilton Mo

17. (a) Burial (b) Date thereof Jan 1, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Congillen Congill, Mo

18. (a) Signature of funeral director Braden & Howe

(b) Address Hamilton Mo

19. (a) 1-6-47 (b) Mrs. Nell B. Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30
year 1946 hour 3:00 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 25, 46
to Dec 30, 1946

that I last saw him alive on Dec 29
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis.
Duration 5 yr.

Due to

Due to

Other conditions Asthma (Cardiac)
(Include pregnancy within 3 months of death) 1 yr.

Major findings: Of operations 93D

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)

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 J. M. Jones (M. D. or other) JMD

Address Hamilton, Mo Date signed 1/9/46

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

MOTHER FATHER

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

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

Signed

R. J. A. Brown

Licensed Embalmer No.

3052

P. O. Address

Hamilton 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.