V. S. No. 2
00M—8-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 16 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 41 Primary Registration District No. 3008 Registrar's No. 4

1. PLACE OF DEATH:

(a) County Calloway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution State Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9Y-2M-23d (Specify whether
In this community 9Y-2M-23d
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Miller 54
(c) City or town Miller County Home
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Ellen Smith

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

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 22 (Day) 1887 (Year)

8. AGE: Years 59 Months 6 Days 13 If less than one day hr. min.

9. Birthplace DK (City, town, or county) 9 (State or foreign country)
10. Usual occupation none 1
11. Industry or business

FATHER
12. Name DK 9
13. Birthplace DK (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Mary Ellen Smith 2
15. Birthplace DK (City, town, or county) 7 (State or foreign country)

16. (a) Informant Hospital Record
(b) Address
17. (a) Columbia Mo (b) Date thereof 1 8 47 (Month) (Day) (Year)
~~(Burial, cremation~~ or removal)
(c) Place: burial or cremation Columbia Mo
18. (a) Signature of funeral director J. O. Roberts
(b) Address Columbia Mo
19. (a) 1-8-1947 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-4 47 day
year hour 3.50 AM minute M.
21. I hereby certify that I attended the deceased from 1-2-47, 19, to 1-4-47, 19;
that I last saw her alive on 1-3 47, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrage	
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) 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 0
23. Signature J. B. Stokes M.D. (M. D. or other)
Address Fulton Mo. Date signed 1-4-47
By A. Fuego.

58 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number
Date Filed JAN 14 1947

APR 26 1951

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.....

Licensed Embalmer No.....

P. O. Address.....

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.