

FILED MAR 3 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4675

Registration District No. 14

Primary Registration District No. 3025

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Haskell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
411 main St. 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 9 days years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Fulton 99!
(c) City or town Salmon 7
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Hola Smith

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 1 | 5. Color or race White | 6. (a) Single, widowed, married, divorced 2 divorced
6. (b) Name of husband or wife R.B. Smith | 6. (c) Age of husband or wife if alive 4 years
7. Birth date of deceased Feb 1, 1865 (Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 10 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Elisha Johnson

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

14. Maiden name Unknown 9

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

16. (a) Informant Forest Smith

(b) Address Salmon, Ark.

17. (a) Burial (b) Date thereof 2-16-47 (Month) (Day) (Year)

(c) Place: burial or cremation Salmon Cemetery

18. (a) Signature of funeral director William Anthony Ferguson

(b) Address Salmon, Ark.

19. (a) 2-19-47 (b) Beatrice Cook (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14 year 1947 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from 2-11-1947 to 2-14-1947; that I last saw her alive on 2-14-1947 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction Duration 1-6-47

Due to Carcinoma of Colon

Due to _____

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations H&E

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury 0

23. Signature E. B. Bohrer (M. D. or other) MD

Address West Plains, Mo. Date signed 2-19-47

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

MOTHER FATHER

RECEIVED

District Registrar Officer No. 5,

District File No. 247 100

Date Filed 2-28-97

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 J. H. Best

Licensed Embalmer No. 659

P. O. Address Embaler, Ark.

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.