

FILED MAY 12 1947

Registration District No. 374

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6275

State File No.

16312

Registrar's No.

21

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Rural - Smith township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 48 years years, months or days

3. (a) PRINT FULL NAME Perry Eugene 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 Audra 6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased June (Month) 1 (Day) 1884 (Year)

8. AGE: Years 62 Months 10 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business Farming

12. Name William Smith

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

14. Maiden name Lura King

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

16. (a) Informant Mrs Audra Smith

(b) Address Alcendale, Mo.

17. (a) Burial 1947 (b) Date thereof April 22, 1947 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation High Cemetery

18. (a) Signature of funeral director Jack E. Duffer

(b) Address Grant City, Mo.

19. (a) April 26, 47 (b) John E. Dawson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Smith township (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20 year 1947 hour 5 minute 10 A.M.

21. I hereby certify that I attended the deceased from April 4th to April 20 that I last saw him alive on April 18 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Leukemia

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 O. L. Lullerton (M. D. or other) Address Redding Iowa Date signed 4/22/47

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..... *Arch C. Dunfee*

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.