

No. 2
-1/47
-17-39

FILED JUL 14 1947
Registration District No.

Primary Registration District No. **1000**

Registrar's No. **811**

1. PLACE OF DEATH:

(a) County **Buchanan**

(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **718 N 8th St-Wayne Private Hosp.**
(If not in hospital or institution, write street name and location)

(d) Length of stay: In hospital or institution **1 to week**
58 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan** //

(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")

(d) Street No. **102 South 13th St.**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Laura Belle Smith**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

4. Sex **Female**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **widow**

6. (b) Name of husband or wife **William**

6. (c) Age of husband or wife if alive **3-28-1869** years

7. Birth date of deceased (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **25**
year **1947** hour **6** minute **15A** M.

21. I hereby certify that I attended the deceased from **June 14** 19**45** to **June 16** 19**47**
that I last saw her alive on **June 16** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myeloid leukemia**

Duration **2 yrs.**

Due to **XX**

Due to **XX**

Other conditions **Lues**
(Include pregnancy within 3 months of death)

Duration **4 yrs.**

PHYSICIAN

Major findings:
Of operations **XX**

Of autops: **XXX**

8. AGE: Years **78** Months **2** Days **27** If less than one day
hr. min.

9. Birthplace **Garrettsburg, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business **home**

12. Name **unknown**

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

14. Maiden name **unknown** **unknown**

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

16. (a) Informant **Harry S. Wilcox**
(b) Address **3302 Doniphan Ave, St. Joe, Mo.**

17. (a) **Burial** (b) Date thereof **6-27-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashland Cemetery**

18. (a) Signature of funeral director **Barry Funeral Home**
(b) Address **St. Joseph, Mo.**

19. (a) **7-7-47** (b) **W. W. Jenkins**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **XX**

(b) Date of occurrence **XX**

(c) Where did injury occur? **XX**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **XX**
While at work? **XX** (Specify type of place) (e) Means of injury **6**

23. Signature **B. H. Kerner** (M. D. or other) **6**
Address **Kirkpatrick Bldg.,** Date signed **6-30-47**
St. Joseph, Mo.

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

MOTHER FATHER

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..... *Victor Barry*

Licensed Embalmer No..... *4212*

P. O. Address..... *St Joseph 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.