

FILED AUG 26 1947

Registration District No. _____

Primary Registration District No. 5102

Registrar's No. 29

1. PLACE OF DEATH

(a) County Benton
(b) City or town Fristaer, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether

In this community Life
years, months or days)

3. (a) PRINT FULL NAME SUBYINA JANE SMITH

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased Oct 9 1861
(Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 6 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Iza West

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

14. Maiden name Elizabeth Shaw

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

16. (a) Informant Matilda Maxwell

(b) Address Windsor, MO

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

(c) Place: burial or cremation Fristaer Cemetery

18. (a) Signature of funeral director River Funeral Home

(b) Address Warsaw, MO

19. (a) 8/19/47 (b) Mo. R. Logan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Benton

(c) City or town Fristaer
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15
year 1947 hour 4:00 minute AM

21. I hereby certify that I attended the deceased from 3/16/47 1947 to Aug 15 1947
that I last saw her alive on Aug 14 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 30 days

Due to Senility 1 yr

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?

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature Sussally (M. D. or other) DO

Address Warsaw, MO Date signed 8/15/47

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

303

RECEIVED
District Health Officer No. 71
District File Number 7-47-1006
Date Filed 8-28-47

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.....

Jack W. Reser....., Registered Apprentice No. 12
working under my personal supervision.

Signed..... *John F. Reser*
Licensed Embalmer No. 4098
P. O. Address..... Warsaw

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.