

FILED OCT 7 1947

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 343

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Union
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 years 3 months
(Specify whether years, months or days) same.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Boone 14
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. Route # 5. 2
(If rural, give location) 0
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MAGGIE SMITH.

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

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Sam E. Smith 6. (c) Age of husband or wife if alive DN years 30 1880
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 4 29 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Ira Walk 1
13. Birthplace Iowa (State or foreign country)
14. Maiden name Sadie Wade
15. Birthplace Mo. (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Fulton Mo.

17. (a) ~~Funeral~~ (b) Date thereof 9-29-1947
(Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery
Forbes Funeral Service

18. (a) Signature of funeral director _____

(b) Address 18 N. 10 St. Columbia, Mo.

19. (a) 9-29-1947 (b) Joan Morosoff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 29
year 1947 hour 12 minute 28 P.M.

21. I hereby certify that I attended the deceased from 9-25/47, 1947 to 9-29/47, 1947;
that I last saw ER alive on 9/29/47, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death malnutrition. Duration _____

Due to Paralysis Agitans.
Due to Arteriosclerosis.

Other conditions (Include pregnancy within 3 months of death) 1870

Major findings: Of operations _____
Of autopsy Primary cause
Incontinence + malnutrition
cont. Paralysis Agitans + Hypostatic congestion.

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

(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) (e) Means of injury _____

23. Signature R.P. Price (M.D. or other) MD

Address Fulton Mo. Date signed 9/29/47
H. A. Fungo.

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

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RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 10-6-47

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Tom McFarq
Licensed Embalmer No. 4067
P. O. Address Columbia, 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.