

No. 2  
 OM-5-43  
 v. 5-17-39  
 I X3667

State File No. **33874**  
 Registrar's No. **317**

FILED OCT 21 1947

Registration District No. **33** Primary Registration District No. **3010**

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

1. PLACE OF DEATH:  
 (a) County Cape Girardeau, Co.  
 (b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Francis Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County New Madrid  
 (c) City or town Portageville  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? No  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Donald Ray Smith  
 3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex M 5. Color or race white  
 6. (a) Single, widowed, married, divorced ✓  
 6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years  
 7. Birth date of deceased Sept 27 1947  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 8 1/2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Cape Girardeau Mo  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Infant

11. Industry or business ✓  
 12. Name unknown  
 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 14. Maiden name Batrice Smith  
 15. Birthplace Cardwell Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Carrie Bell Robinson  
 (b) Address R#2 Portageville Mo  
 17. (a) Burial (b) Date thereof 10-6-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Portageville, Mo

18. (a) Signature of funeral director W. E. Pike  
 (b) Address Portageville, Mo  
 19. (a) 10-15-1947 (b) G. G. Sumner  
(Date received local return) (Registrar's signature)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct day 5  
 year 1947 hour 7 minute 56 P.  
 21. I hereby certify that I attended the deceased from 9/27, 1947, to 10/5, 1947  
 that I last saw him alive on \_\_\_\_\_, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death REMORA RITX  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions ATELECTASIS  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations 159  
 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? 0  
 While at work? at death (Specify type of place) (c) Means of injury falls  
 23. Signature W. E. Pike (M. D. or other) MD  
 Address Cape Girardeau Date signed 10/5/47

IVED

Health Officer No. 4

File Number 1047-1330

Date Filed 10-20-47

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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.....

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.**