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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 12 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 210

Primary Registration District No. 5773

Registrar's No. 121

1. PLACE OF DEATH:

(a) County Mercer

(b) City or town Morgan  
(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 \_\_\_\_\_  
In this community all his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Mercer

(c) City or town Morgan Camp. 65  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Stewart 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 Widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 12 - 1 - 1868  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 26 day \_\_\_\_\_  
year 1948 hour 2:10 minute P M.

21. I hereby certify that I attended the deceased from March 24  
1948, to March 26, 19 48  
that I last saw him alive on March 26, 19 48  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>4</u>	<u>25</u>	hr. _____ min.

Immediate cause of death Coronary Occlusion *Debatable* 5 days

Due to Coronary artery disease Unk.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 94w

Major findings: Of operations \_\_\_\_\_

Of autopsy None allowed

PHYSICIAN  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Roach Smith

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

14. Maiden name Unknown 9  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Ray Smith

(b) Address Uniontown, Mo

17. (a) Burial (b) Date thereof 3-29-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Yoshen

18. (a) Signature of funeral director Noel Moss

(b) Address Uniontown, Mo

19. 3-30-48 (b) M. G. Ruth  
(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) \_\_\_\_\_

(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)  
(c) Means of injury 0

23. Signature A. B. Bristow (M. D. or other) MD  
Address Uniontown, Mo Date signed 3/27/48

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

5  
0  
0

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

Signed Noel Mess  
Licensed Embalmer No. 2634  
P. O. Address Funiator 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.