No. 2
1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 27 1948
Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11360
Primary Registration District No. 3000
Registrar's No. 125

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville 4
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Nursing Home 7
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Linn 58
(c) City or town Marceline 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

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

4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ✓
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Sept (Month) 29 (Day) 1881 (Year)

8. AGE: Years 66 Months 6 Days 15 If less than one day hr. min.

9. Birthplace Schuyler Co (City, town, or county) Mo (State or foreign country) 9
10. Usual occupation House Keeper
11. Industry or business
FATHER
12. Name Stanberry Smith 9
13. Birthplace unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Ruth
15. Birthplace unknown (City, town, or county) (State or foreign country) 9
16. (a) Informant Mrs. Allie Edrington
(b) Address Marceline Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 15 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Olivet
18. (a) Signature of funeral director James McLaughlin
(b) Address Marceline Mo
19. (a) 4-17-48 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1948 hour 9 minute A M.
21. I hereby certify that I attended the deceased from April 2, 1948, to April 14, 1948, that I last saw her alive on April 13, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Inanition malnutrition — Duration weeks
Due to Malignancy of stomach — P
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place) ✓
While at work? (e) Means of injury ✓
23. Signature M. T. Gutensohn (~~M.D.~~ or other) D.O.
Address Kirksville, Mo Date signed 4-14-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 1
District File Number 4-48-7
Date Filed APR 26 1948

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 Blanche M Laughlin

Licensed Embalmer No. 1909

P. O. Address Marceline 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.

No. 2B
—3-45
PI X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 121

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Mary A. 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 S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 29 years

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

8. AGE: Years 66 Months 6 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April 14
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Malignancy of stomach

Due to Autopsy refused.

Other conditions primary sept
(Include pregnancy within 3 months of death)

Major findings:
Of operations unknown ?

Of autopsy HGE

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature M. T. Gutensohn (M.D. or other) DO

Address Date signed

SUPPLEMENTARY

S-11360