

Registration District No. 274

Primary Registration District No. 3052

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

Registrar's No. 1-90

1. PLACE OF DEATH:  
(a) County Pettis  
(b) City or town SEBASTIA  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Bothwell Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 DAY  
(Specify whether wife) (Specify whether \_\_\_\_\_)  
In this community wife  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County Benton  
(c) City or town WARSAW  
(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 MARY MITA SMITH  
(b) If veteran, name war NO  
(c) Social Security No. NO

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month JUNE day 29  
year 1948 hour 9 minute 00 P.M.

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 alive \_\_\_\_\_ years  
7. Birth date of deceased OCT 28 1862  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 27, 1948, to June 29, 1948  
that I last saw her alive on June 29, 1948,  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
85 8 1 hr. min.

Immediate cause of death  
Due to Heart failure  
Valvular disease chronic  
Myocardial insufficiency -  
decompensated,  
Due to Nephritis chronic  
ischaemic

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation HOUSEWIFE

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

11. Industry or business HOME  
12. Name WILLIAM H ARNETT  
13. Birthplace MO  
(City, town, or county) (State or foreign country)  
14. Maiden name ELIZABETH NEWBERRY  
15. Birthplace MO  
(City, town, or county) (State or foreign country)

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

16. (a) Informant ALVIN SMITH  
(b) Address Fristoe, MO

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

17. (a) BURIAL (b) Date thereof JULY 1, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? \_\_\_\_\_

(c) Place: burial or cremation BETHEL CAMP GROUND

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of work) \_\_\_\_\_

18. (a) Signature of funeral director John F. Resner  
(b) Address Warsaw, MO  
19. (a) 6-30-48 (b) Betty Yeager  
(Date received local registrar) (Registrar's signature) Deputy

23. Signature Chas. D. Brown (M. D. or other) M.D.  
Address Sebastian MO Date signed 7/30/48

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

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7-7-48  
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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.....

*John F. Resw*

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.**