

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

21849

FILED JUL 10 1948

State File No. _____

Registration District No. 323

Primary Registration District No. 6090

Registrar's No. 50

1. PLACE OF DEATH:

(a) County... SALINE
 (b) City or town... LIBERTY TWP RURAL
 (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... 25 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... Mo (b) County... SALINE 97
 (c) City or town... RURAL
 (If outside city or town limits, write "RURAL")
 (d) Street No... N. EDGE of LIBERTY TWP
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country: _____

3. (a) PRINT FULL NAME RUBEN SMITHEY

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... JANE SMITHEY
 6. (c) Age of husband or wife if alive... DEAD 17 years
 7. Birth date of deceased... SEPT 14, 1861
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 9 12 hr. min.

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

10. Usual occupation... FARMER

11. Industry or business... TILLER of SOIL

12. Name... ROBERT SMITHEY

13. Birthplace... NOT KNOWN
 (City, town, or county) (State or foreign country)

14. Maiden name... NOT KNOWN

15. Birthplace... NOT KNOWN
 (City, town, or county) (State or foreign country)

16. (a) Informant... FORREST SMITHEY

(b) Address... SWEET SPRINGS, Mo

17. (a) BURIAL (b) Date thereof... 4/29/48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation... ANTOCH CEMETRY

18. (a) Signature of funeral director... R. E. CARTER

(b) Address... SWEET SPRINGS, Mo

19. (a) 4/29/48 (b) Dolly Andrew
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month... June day... 26
 year... 1948 hour... 7 minute... P.M.

21. I hereby certify that I attended the deceased from... June 24, 1948, to... June 23, 1948
 that I last saw him alive on... June 29, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death... Cerebral Paralysis
 Duration... 5 days

Due to...
 Due to...

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

Major findings: 83 D
 Of operations...

Of autopsy...

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... John M. Neush (M-D) 2018

Address... Houstonia Date signed... 6.28.48

PHYSICIAN

Underline the cause of which death should be charged statistically.

MOTHER FATHER

REC'D
District Health Officer No. 1
District File Number
Date Filed 7-9-48

1951 ST 1414

JUL 12 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 W. C. Carter
Licensed Embalmer No. 3513
P. O. Address West Long

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.