

No. 2
1/47
17-39

FILED AUG 24 1948
Registration District No. **197**

Primary Registration District No. **3023**

Registrar's No. **174**

1. PLACE OF DEATH:

(a) County **Henry**

(b) City or town **Clinton mo**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Clinton General Hospital**
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution **7 day** Specify whether

In this community **7 day** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **HENRY 42**

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

(d) Street No. **701 EAST FRANKLIN**
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME **ARLE RICHARD SMITH**

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUG** day **17**
year **1948** hour **6:10 pm** minute M.

21. I hereby certify that I attended the deceased from **JUNE 18** 19**48** to **AUG. 17** 19**48**
that I last saw him alive on **AUG. 17** 19**48**
and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **mar**

6. (b) Name of husband or wife **Pearl Smith** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **Oct 17 1888**
(Month) (Day) (Year)

Immediate cause of death **BRONCHIAL PNEUMONIA AND APOPLEXY**

8. AGE: Years **64** Months **10** Days **X** If less than one day hr. min.

Due to **HYPERTENSION**

Other conditions (Includes pregnancy within 3 months of death)

9. Birthplace **HALE MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **MILL WRIGHT**

Major findings: Of operations **107**

Of autopsy

PHYSICIAN

Underline the cause of which death should be charged statistically.

11. Industry or business

12. Name **ALBERT P. SMITH**

13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

14. Maiden name **ANGELINE HAST**

15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Ed Long**

(b) Address **Clinton mo**

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)

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof **8-20-48**
(Month) (Day) (Year)

(c) Place: burial or cremation **Englewood Cem**

(e) Means of injury

23. Signature **Hugh B Walker, MD** (D. or other)

Address **Clinton, MO** Date signed **August 1948**

18. (a) Signature of funeral director **Consuelo Beck**

(b) Address **Clinton MO**

19. (a) **8-19-48** (Date received local registrar) (b) **R. P. Kennedy** (Registrar's signature)

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

2
1

MAR 8 1949

RECEIVED
District Health Officer No. 7,
District File Number 7-48-967
Date Filed 8-23-48

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 J E Cousins
Licensed Embalmer No. 1891

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.