

No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JAN 11 1949

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

40830

Registration District No. 218

Primary Registration District No. 4330

State File No. _____

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town East Prairie, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Whiting Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 39 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi

(c) City or town East Prairie
(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 GEORGE F. SMITH

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 2nd
year 1948 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from 1st June 1948 to 26th Nov. 1948
that I last saw him live on Nov. 26 and that death occurred on the date and hour stated above.

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: Oct. 23 1870
(Month) (Day) (Year)

Immediate cause of death was due to general weakness
Duration _____

Due to Cancer of Tongue

Due to _____

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>1</u>	<u>9</u>	hr. _____ min. _____

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

Major findings: Of operations _____

Of autopsy 45

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

9. Birthplace: Spencer Co. Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Richen Smith

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

14. Maiden name Rhodica Powers

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

16. (a) Informant Dezigi Smith

(b) Address 1703 Gayflette, St. Louis Mo.

17. (a) Burial (b) Date thereof Dec. 5 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S.O.O.F. Cem. Charleston

18. (a) Signature of funeral director James Shelby

(b) Address East Prairie, Mo.

19. (a) Jan 6 1949 (b) Anna Harper
(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)

(e) Means of injury 17

23. Signature A.J. Martin (M. D. or other) _____
Address East Prairie Mo Date signed 12-7-48

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

7
2
0

RECEIVED

District Health Office No. 2

District File Number 149-39

Date Filed 1-10-69

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.....

Travis Shelby

Licensed Embalmer No. 2726

P. O. Address East Prarie, 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.

Registration District No. 218

Primary Registration District No. 4330

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town East Prairie
(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

3. (a) PRINT FULL NAME

George F Smith

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct 23
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days _____
(If less than one Day) hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

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

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to Cancer of Tongue

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature A. J. Martin (M. D. or other) _____

Address East Prairie Mo Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

S-40830