

FILED FEB 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1688

BIRTH NO. _____ REG. DIST. NO. 169 PRIMARY REG. DIST. NO. 4263 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY Knox		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Knox	
b. CITY (If outside corporate limits, write RURAL and give township) Novelty		c. CITY (If outside corporate limits, write RURAL and give township) Novelty	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) Stella Mae Smith			4. DATE OF DEATH (Month) (Day) (Year) Jan - 29 - 1949			
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June-7-1891	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days	IF UNDER 14 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Macon County, Missouri. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Levie Cowles	13b. MOTHER'S MAIDEN NAME Electa Howerton	14. NAME OF HUSBAND OR WIFE Earnest Smith
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Albert Cowles LaBelle MD	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Jan 22-49 to Jan 29-49
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Epilepsy		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> None of it		
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 22, 1949**, to **Jan 29, 1949**, that I last saw the deceased alive on **Jan 29, 1949**, and that death occurred at **5:45 p.m.** (from the causes and on the date stated above).

23a. SIGNATURE E. O. Holmes D.O.	23b. ADDRESS Novelty Mo	23c. DATE SIGNED Jan 31-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb-1-1949	24c. NAME OF CEMETERY OR CREMATORY Novelty Cemetery
24d. LOCATION (City, town, or county) Novelty, Missouri.		

DATE REC'D BY LOCAL REG. Feb-1-1949	REGISTRAR'S SIGNATURE John S. Nunant 51	25. FUNERAL DIRECTOR'S SIGNATURE Ruth Hudson	ADDRESS Edina, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED

District Health Officer No. 10

District File Number 2-49-26

Date Filed FEB 8 - 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Keith Hudson

Signed _____
Student Embalmer

Licensed Embalmer No. 2415

P. O. Address Edina, Missouri

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.