

THE DIVISION OF HEALTH OF MISSOURI  
FILED JUN 29 1949 STANDARD CERTIFICATE OF DEATH

20079

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 169 PRIMARY REG. DIST. NO. 5617 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY <u>Knox</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>MISSOURI</u> b. COUNTY <u>KNOX</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>NEWARK (Rural)</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>NEWARK, FABIUS TOWNSHIP</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>1</u>		d. STREET ADDRESS (If rural, give location) <u>NEWARK MISSOURI</u>	
3. NAME OF DECEASED a. (First) <u>ANNA</u> b. (Middle) <u>MARTHA</u> c. (Last) <u>SMITH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 18 1949</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>APRIL 13 - 1863</u>
9. AGE (In years last birthday) <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	11. BIRTHPLACE (State or foreign country) <u>EDINBURG, ILLINOIS</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOHN RICHARDSON</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>ALBERT W. SMITH</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Harrieth Smith</u> ADDRESS <u>Newark, Mo.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Dysentery (Colic)</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocarditis Chronic</u> DUE TO (c) <u>Senility</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>422</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No.</u>		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/6</u> , 1949, to <u>June 18</u> , 1949, that I last saw the deceased alive on <u>June 17</u> , 1949, and that death occurred at <u>404</u> m, from the causes and on the date stated above.			
23a. SIGNATURE <u>H. J. Hilliard, M.D.</u> (Degree or title)		23b. ADDRESS <u>Net Belle Mo.</u>	
23c. DATE SIGNED <u>June 20, 1949</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>June 20 - 49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Newark I.O.O.F.</u>		24d. LOCATION (City, town, or county) (State) <u>Newark, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>June 22 - 49</u>		REGISTRAR'S SIGNATURE <u>Thos. Ball</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. Ball</u> ADDRESS <u>Ewing, Mo.</u>			

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

RECEIVED

District Health Officer No.

District File Number 6-49

Date Filed JUN 28 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.

Student .....  
Student Embalmer

Signed

*Thomas Baer*

Licensed Embalmer No. 1744

P. O. Address Ewing, 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.