

FILED NOV 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34461

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>218</u>		PRIMARY REG. DIST. NO. <u>5788</u>		Registrar's No. <u>54</u>		
1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>Charleston(rural)</u>		c. LENGTH OF STAY (in this place) <u>26 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Charleston (rural)</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Henson community R. 1, Box 71</u>				d. STREET ADDRESS (If rural, give location) <u>R.1, Box 71, Henson community</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Will</u>		b. (Middle)		c. (Last) <u>Smith</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 17, 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 25, 1884</u>		
9. AGE (in years last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>22</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Atlanta, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ed Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Belzoni Smith, deceased</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Sarah Glisspie</u> ADDRESS <u>R.1, Box 71, Charleston, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial degeneration</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>  <u>4222</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 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>April 1949</u> , to <u>Oct 17, 1949</u> , that I last saw the deceased alive on <u>Oct 17, 1949</u> , and that death occurred at <u>6:00P</u> m., from the causes and on the date stated above.								
23a. SIGNATURE (Name or title) <u>D. P. Feiler</u>				23b. ADDRESS <u>Wyatt Mo.</u>		23c. DATE SIGNED <u>10-22/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 20, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Oct. 28, 1949</u>		REGISTRAR'S SIGNATURE <u>Harry Dyer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Sparkes</u>		ADDRESS <u>Charleston Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 15 1950

NOV 8 1949

RECEIVED NOV 11 1949

Health Co. Health Dept.

County File No. \_\_\_\_\_

Date Filed NOV 4 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 Frank Sparks

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3453

P. O. Address Pepe G. ...

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.