

FILED NOV 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36231

BIRTH NO. _____		REG. DIST. NO. <u>8</u>		PRIMARY REG. DIST. NO. <u>4021</u>		Registrar's No. <u>12</u>	
1. PLACE OF DEATH a. COUNTY <u>Audrain</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Audrain</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Ladonia, Mo.</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Ladonia, Mo.</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Residence - Ladonia, Mo.</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Alvin</u>		b. (Middle) <u>Britton</u>		c. (Last) <u>Smith.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 12, 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married.</u>	8. DATE OF BIRTH <u>July 2, 1889</u>	9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Days <u>4</u>	IF UNDER 2 HRS. Hours _____	IF UNDER 15 MIN. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming + seed buying</u>		11. BIRTHPLACE (State or foreign country) <u>Lincoln County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Britton Smith.</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Holcomb.</u>		14. NAME OF HUSBAND OR WIFE <u>Ruth 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>Mrs. Ruth Smith</u>		ADDRESS <u>Ladonia, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Angina Pectoris</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (c) <u>Carcinoma of Right Axillary glands-6-M</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10-Hrs</u> <u>181</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) _____ m.		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>Nov 11, 1949</u> , to <u>Nov 12, 1949</u> , that I last saw the deceased alive on <u>Nov 11, 1949</u> , and that death occurred at <u>2 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W K McKeel M.D.</u>				23b. ADDRESS <u>Ladonia Mo</u>		23c. DATE SIGNED <u>11-12-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 13, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ladonia Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Ladonia Mo.</u>	
DATE REC'D BY LOCAL REG. <u>11-12-49</u>		REGISTRAR'S SIGNATURE <u>Martha Kammemo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clyde C. Wilsey</u>		ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

RECEIVED NOV 23 1949
District Health Officer No. 10
District File Number 11-49-196
Date Filed NOV 23 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 *Clyde C. Wilkey*.....

Licensed Embalmer No. *3820*.....

P. O. Address *Perry, 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.