

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41628

BIRTH NO. _____		REG. DIST. NO. <u>184</u>		PRIMARY REG. DIST. NO. <u>3038</u>		Registrar's No. <u>240</u>	
1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Brookfield</u>		c. LENGTH OF STAY (in this place) <u>2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Catherine</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McLarney Hospital</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) <u>NINA MAE SMITH</u>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 9, 1949</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 18, 1925</u>	
9. AGE (In years last birthday) <u>24</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Brookfield, Mo. (8)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13a. FATHER'S NAME <u>Roby Lineberry</u>			13b. MOTHER'S MAIDEN NAME <u>Lily Godsey</u>		14. NAME OF HUSBAND OR WIFE <u>Donald D. 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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Donald D. Smith, St. Catherine, 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>Eclampsia</u> ANTECEDENT CAUSES <u>Chronic Pyelonephritis</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Caesarian Section - 12.8.49</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>12 yrs</u> <u>12423</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>3rd girl by born by her Caesarian Section</u>				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) _____		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>Jan 15, 1948</u> to <u>Dec 9, 1949</u> , that I last saw the deceased alive on <u>Dec 9, 1949</u> , and that death occurred at <u>5:55 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Woy R. Haley</u> (Degree or title) _____				23b. ADDRESS <u>Brookfield Mo.</u>		23c. DATE SIGNED <u>12.11.49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 12, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Brookfield, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12-12-49</u>		REGISTRAR'S SIGNATURE <u>H. B. Erwin</u> <u>1670</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wright Funeral Home, Brookfield, Mo.</u>			

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



**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 H. B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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.