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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42185

State File No. ....

FILED JAN 4 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 6061 Registrar's No. 52

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Collins - Dallas - T.S</u>		c. LENGTH OF STAY (in this place) <u>25 years</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Collins - Dallas Township</u>		43
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5 mi. N. East</u>			d. STREET ADDRESS (If rural, give location) <u>5 miles N. East of Collins</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Thomas</u> c. (Last) <u>Smart</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 3 - 1949</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Aug - 14 - 1868</u>		9. AGE (In years last birthday) <u>81</u> if UNDER 1 YEAR Months <u>3</u> Days <u>19</u> if UNDER 24 HRS. Hours Min.
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>None</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Chas. N. Southern</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>Archie Smart</u> ADDRESS _____		

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</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>4222</u>
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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 5/20, 1949, to 7/9, 1949, that I last saw the deceased alive on 7/9, 1949, and that death occurred at 9 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. W. Robinson M.D.</u>		23b. ADDRESS <u>Thermansville Mo</u>		23c. DATE SIGNED <u>12/12/49</u>
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24a. BURIAL - CREMATION REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec 5 - 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Thermansville, Mo</u>	
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DATE REC'D BY LOCAL REG. <u>Dec 20 - 49</u>	REGISTRAR'S SIGNATURE <u>Paul Secor</u> 288	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert Bethaway</u>		
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
District Health Officer No. 7,  
District File Number 11-49-151  
Date Filed 12-28-47

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 Chas Gilbert Hathaway

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

Licensed Embalmer No. 4267

P. O. Address Wheatland, W.V.

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.