

FILED DEC 27 1949

# STANDARD CERTIFICATE OF DEATH

State File No. **43379**
 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **328** PRIMARY REG. DIST. NO. **3073** Registrar's No. **41**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Scott</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Scott</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Chaffee</b>	c. LENGTH OF STAY (in this place) <b>394r</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Chaffee</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>✓</b>		d. STREET ADDRESS (If rural, give location) <b>10</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Sarah</b> b. (Middle) <b>Catherine</b> c. (Last) <b>Smith</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Dec 12, 1949</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Married 1</b>	<b>8. DATE OF BIRTH</b> <b>Oct 31, 1878</b>	<b>9. AGE (In years last birthday)</b> <b>71</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 2 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House wife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>✓</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Bahard Co. Ky. 1</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>

<b>13a. FATHER'S NAME</b> <b>Fred Crice</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Melissa Garner</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Walter C. Smith</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <b>Mrs. O.E. Rigdon Chaffee, Mo</b>

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)	<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Sudden Death</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Natural Cause</b> DUE TO (c) <b>Choke</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 1/2 Hours</b>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>Probably Heart Failure 7925</b>		

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>

<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
<b>22. I hereby certify that I attended the deceased from</b> <b>12/12/49</b> , 19 <b>49</b> , to <b>12/12/49</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>12/12/49</b> , 19 <b>49</b> and that death occurred at <b>102</b> m., from the causes and on the date stated above.		

<b>23a. SIGNATURE</b> (Degree or title) <b>W.P. Cready M.D.</b>	<b>23b. ADDRESS</b> <b>Chaffee, Mo</b>	<b>23c. DATE SIGNED</b> <b>12/13/49</b>	
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>24b. DATE</b> <b>12-14-49</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Park</b>	<b>24d. LOCATION (City, town, or county) (State).</b> <b>Cape Girardeau Mo</b>
<b>DATE REC'D BY LOCAL REG.</b> <b>12/14/49</b>	<b>REGISTRAR'S SIGNATURE</b> <b>H.B. MacCready 298</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Bisplinghoff Funeral Home Chaffee Mo</b>	

RECEIVED DEC 20  
District Health Office N  
District File Number 1249  
Date Filed \_\_\_\_\_

**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

*Mamie B. Dupleighoff*

Licensed Embalmer No. 3242

P. O. Address Chaffee 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.