DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1948

Registration District No. 239

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9510

Primary Registration District No. 4350

Registrar's No. 5

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

1. PLACE OF DEATH:

(a) County: Morgan

(b) City or town: Syracuse
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Montcalm

(c) City or town: Rural
(If outside city or town limits, write "RURAL") 68

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No) O
If yes, name country ____

3. (a) PRINT FULL NAME: Emma Matilda Smith

3. (b) If veteran, name war ____

3. (c) Social Security No. 2

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: Feb (Month) 16 (Day) 1870 (Year)

8. AGE: Years 78 | Months 1 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace: Jamestown (City, town, or county) O (State or foreign country)

10. Usual occupation: House wife

11. Industry or business ____

FATHER
12. Name: Unknown
13. Birthplace: ? (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name: Bussell
15. Birthplace: Kentucky (City, town, or county) 9 (State or foreign country)

16. (a) Informant: A W Smith

(b) Address: Syracuse Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/48 (Month) (Day) (Year)

(c) Place: burial or cremation: Jamestown Fullerton

18. (a) Signature of funeral director: Elmer Fullerton

(b) Address: Jamestown

19. (a) 4/3/48 (Date received local registrar) (b) Myrta Hatsenpiller (Registrar's signature) 312

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day First
year 1948 hour 4:00 AM minute ____ M.

21. I hereby certify that I attended the deceased from March 16th, 1948, to March 04th, 1948, that I last saw her alive on Wed. March 24th 1948; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion, due to	
Generalized arterio-sclerosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 9 10
Of autopsy ____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature: D C Faulkner (M. D. or other) D.O.

Address: Tipton, Mo. Date signed 4-1-48

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed H E Friedmeyer

Licensed Embalmer No. 2854

P. O. Address California No

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B —3-45 I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Copied

Registration District No. 23 J^ Primary Registration District No. 43 S D Registrar's No. 5

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

1. PLACE OF DEATH:

(a) County Morgan (b) City or town Syracuse
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montrail

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? Natural (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Emma M Smith

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 18 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country) Mo

10. Usual occupation

11. Industry or business

MOTHER / FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4/7/45 (Date received local registrar) (b) Myrta Stevens Miller (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

S-9510