No. 300
10-47
5-17-39
I-3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 1 1948
Registration District No. 316

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27426
Primary Registration District No. 3059
Registrar's No. 273

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Bonne Terre (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonne Terre Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Two Weeks (Specify whether years, months or days) In this community life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francois
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Farmington Route 2 (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary E. Smith
3. (b) If veteran, name war
3. (c) Social Security No. none

4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Henry Smith
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 25 (Day) 1873 (Year)

8. AGE: Years 75 Months 4 Days 28 If less than one day hr. min.

9. Birthplace Ste. Genevieve County Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Care of Home
11. Industry or business

FATHER
12. Name Soloman Mackley
13. Birthplace Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lucinda Pinkston
15. Birthplace Ste. Genevieve Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Willard Mc-Carty
(b) Address Desloge, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof August 25-48 (Month) (Day) (Year)
(c) Place: burial or cremation Marvin Chapel
18. (a) Signature of funeral director C. Z. Boyer & Son
(b) Address Desloge, Missouri
19. (a) 8-25-48 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23 year 1948 hour 11 minute 55 A.M.
21. I hereby certify that I attended the deceased from Aug 1947, 19__ to Aug 23, 1948, that I last saw her alive on Aug 22 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Heart failure	
Due to Arteriosclerotic heart disease	
Due to	
Other conditions. Fracture of humerus (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 [illegible] (M. D) or other)
Address Farmington Mo. Date signed 8/25/48

(Licensed Embalmer's Statement on Reverse Side)

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

EXAMINED

District Health Officer No. 4

District File Number 848-1

Date Filed 8-31-48

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 B F Daye

Licensed Embalmer No. 3660

P. O. Address Okolona Miss

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.

No. 2B
M-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. Sept

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 873

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(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
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary E 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 years
7. Birth date of deceased March 25 (Month) (Day) (Year)
8. AGE: Years 75 Months 4 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23 year 1948 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 acc. not cause of death	
Other conditions (Include pregnancy within 3 months of death) death. 95	
Major findings: Of operations Heart trouble	
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) no.
(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 Dr. Geo. L. Watkins (M. D. or other)
Address Farmington Mo. Date signed 9-9-48.

5-27426