

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30077**
Registrar's No. **509**

No. 300
10-48

60772 - 57
FILED OCT 2 1951

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023**

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

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Henry | | 2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission). a. STATE Missouri b. COUNTY Henry | |
| b. CITY (If outside corporate limits, write RURAL and give township) Clinton | | c. CITY (If outside corporate limits, write RURAL and give township) Clinton | |
| c. LENGTH OF STAY (in this place) | | d. STREET ADDRESS (If rural, give location) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Clinton General | | | |

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|---|-------------------------------|---|--|---|--|---|----------------------------------|
| 3. NAME OF DECEASED (Type or Print) a. (First) Jo | | b. (Middle) Jonathin | | c. (Last) Smith | | 4. DATE OF DEATH (Month) (Day) (Year) 9-25-51 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) Single | | 8. DATE OF BIRTH 9-25-1951 | | 9. AGE (in years last birthday) | IF UNDER 1 YEAR Months 12 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Clinton Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | |

| | | | | | |
|--------------------------------------|--|--|--|--|--|
| 13a. FATHER'S NAME Jack Smith | | 13b. MOTHER'S MAIDEN NAME Jo Carol Keifer | | 14. NAME OF HUSBAND OR WIFE ----- | |
|--------------------------------------|--|--|--|--|--|

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|--|--|-------------------------------------|--|---|--|---------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME Jack Smith Osceola Mo. | | ADDRESS | |
|--|--|-------------------------------------|--|---|--|---------|--|

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|---|--|--|--|--|--|---|
| 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 | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Heart Defect | | | | | |
| | ANTECEDENT CAUSES Morbidity 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 contributing to the death but not related to the disease or condition causing death. 7544 | | | | | | |

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|------------------------|----------------------------------|--|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|----------------------------------|--|--|--|

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|--|--|--|--|---|--|
| 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) | |
|--|--|--|--|---|--|

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|---|--|--|--|----------------------------|--|
| 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 **9-25-1951**, to **9-25-1951**, that I last saw the deceased alive on **9-25-1951**, and that death occurred at **9:36 p.m.**, from the causes and on the date stated above.

| | | | | | |
|---|--|---------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE (Degree or title) H. Walker, M.D. | | 23b. ADDRESS Clinton Mo. | | 23c. DATE SIGNED 9-26-51 | |
|---|--|---------------------------------|--|---------------------------------|--|

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|---|--|----------------------------|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 9-27-1951 | | 24c. NAME OF CEMETERY OR CREMATORY Osceola | | 24d. LOCATION (City, town, or county) (State) Osceola Missouri | |
|---|--|----------------------------|--|---|--|---|--|

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|--|--|---|--|---|--|----------------------------|--|
| DATE REC'D BY LOCAL REG. Sept 27-51 | | REGISTRAR'S SIGNATURE Florence Adair | | 25. FUNERAL DIRECTOR'S SIGNATURE F.B. Goodrich | | ADDRESS Osceola Mo. | |
|--|--|---|--|---|--|----------------------------|--|

RECEIVED 10-1-51
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 10-1-51

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 J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola, 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.