

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

1050

State File No.

FILED FEB 1 1954

BIRTH NO. _____ REG. DIST. NO. 132 PRIMARY REG. DIST. NO. 3021 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>Grundy</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Grundy</u>	
b. CITY OR TOWN <u>Trenton</u>	c. LENGTH OF STAY (in this place) <u>1 1/2 yrs</u>	c. CITY OR TOWN <u>Galt</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Susana Nursing Home</u>		d. STREET ADDRESS (If rural, give location) <u>0400</u> <u>0</u>	

3. NAME OF DECEASED (Type or Print) <u>EDITH FLORENCE SMITH</u>			4. DATE OF DEATH <u>1-18-1954</u>		
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)
5. SEX <u>f</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-5-1867</u>		9. AGE (in years last birthday) <u>86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Trenton mo</u>	
13a. FATHER'S NAME <u>John W. Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret McGuire</u>		14. NAME OF HUSBAND OR WIFE <u>✓</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Cecas Carmell</u>		ADDRESS <u>Galt mo</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis</u>		<u>2 yrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Epilepsy</u> DUE TO (b) DUE TO (c)		<u>2 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>3533</u>	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) m.	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 July 26, 1902, to Jan 18, 1954, that I last saw the deceased alive on Jan 17, 1954, and that death occurred at 3:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>E. C. Duffy M.D.</u>	(Degree or title)	23b. ADDRESS <u>Trenton Mo.</u>	23c. DATE SIGNED <u>Jan 19 1954</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1-20-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Galt Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Galt mo</u>

DATE REC'D BY LOCAL REG. <u>1-20-54</u>	REGISTRAR'S SIGNATURE <u>Jeanne Fair</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>P. K. Payne</u>	ADDRESS <u>Trenton Galt</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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 PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address. Galt

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.