

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18054**

FILED JUN 28 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **637**

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

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Crawford</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>Collinsville</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>10 weeks</b>		e. STREET ADDRESS (If rural, give location) <b>None</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Huntoon Road at Water Works</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>IKE</b>	b. (Middle) <b>THORNTON</b>	c. (Last) <b>SMITH</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 17 1954</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 29, 1904</b>
9. AGE (In years last birthday) <b>50</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13a. FATHER'S NAME <b>Ivan Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Unk</b>	14. NAME OF HUSBAND OR WIFE <b>Florence Smith</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>285-09-9989</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Florence Smith</b> ADDRESS <b>Collinsville, Ill.</b>

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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Rupture of Spleen, Fatal</b>	1 day	
ANTECEDENT CAUSES	DUE TO (b) <b>Hemorrhage, spleen enlarged and friable</b>		Unknown
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) <b>Cirrhosis of the liver</b>		
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death. <b>Fracture of left 7th rib</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>man had an altercation and fight with another man two hours before death</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) <b>Huntoon Road</b>	21c. CITY OR TOWN (If in Missouri) (If in other State or Foreign Country) <b>Washington, Buchanan Mo.</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Jun 17 - 1954 - 3:30 P</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Apparently in a fall</b>

22. I hereby certify that I examined the deceased **born on 6/17, 1904**, to **1954**, that I last saw the deceased alive on **6/17, 1954**, and that death occurred at **4:30 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>H F Mundy (Coroner) M.D.</b>	23b. ADDRESS <b>St Joseph Mo</b>	23c. DATE SIGNED <b>6/18/54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>June 18, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Collinsville, Illinois</b>
24d. LOCATION (City, town, or county) (State) <b>Collinsville, Illinois</b>		

DATE REC'D BY LOCAL REG. <b>June 21, 1954</b>	REGISTRAR'S SIGNATURE <b>Leather M. Allison</b>	48570	FUNERAL DIRECTOR'S SIGNATURE <b>Stame Funeral Home St Joseph, Mo</b>	ADDRESS
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SEP 21 1958

SEP 20 1958

JUL 8 1958

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.....  
Signature of Student Embalmer

Signed *John Roy Plawey*.....

Licensed Embalmer *2435*.....

P. O. Address *H. J. Plawey*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.