

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30330

State File No.

~~FILED~~ SEP 20 1954

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 861

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. LENGTH OF STAY (in this place) c. CITY OR TOWN RURAL CAMPBELL	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BURGE HOSPITAL		e. STREET ADDRESS (If rural, give location) SPRINGFIELD RFD#6 0290	

3. NAME OF DECEASED (Type or Print)	a. (First) PHILLIP	b. (Middle) CLARENCE	c. (Last) SMITH	4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 13, 1954
-------------------------------------	---------------------------	-----------------------------	------------------------	-----------------------------------------------------------------

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 1 SEPT. 1897	9. AGE (In years last birthday) 57	If UNDER 1 YEAR: Months _____ Days _____	If OVER 1 YEAR: Hours _____ Min. _____
--------------------	-------------------------------	-----------------------------------------------------------------------	--------------------------------------	-------------------------------------------	------------------------------------------	----------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and State or Foreign Country) Plymouth Kansas	12. CITIZEN OF WHAT COUNTRY? USA
------------------------------------------------------------------------------------------------------------	--------------------------------------------	---------------------------------------------------------------------------	-----------------------------------------

13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE DECEASED
-----------------------------------	------------------------------------------	---------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME C.O. SPERRY	ADDRESS SPRINGFIELD, MO.
-----------------------------------------------------------------------------	----------------------------------------	------------------------------------------------------	---------------------------------

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) Probable Kerosperitoneal Tumor at least 2. lower abdomen,		mo,
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Starvation + Cachexia wks.		approx 2
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. secondary to mass			

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	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 31 Aug 54 to 13 Sept 54, that I last saw the deceased alive on 13 Sept 54, and that death occurred at 7:50 A.M. from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title) _____	23b. ADDRESS Springfield Mo.	23c. DATE SIGNED 14 Sept 54
-----------------------------------	-------------------------	-------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 15, 1954	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
---------------------------------------------------------	---------------------------------	--------------------------------------------------------------	----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 9-15-54	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS SPRINGFIELD, MO.
-----------------------------------------	------------------------------------------	-----------------------------------------------------	---------------------------------

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

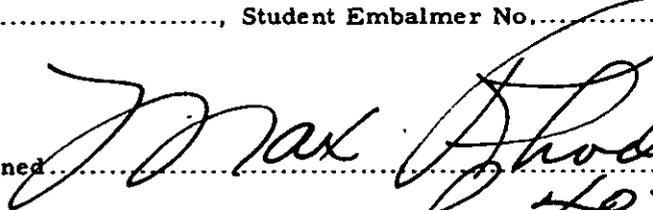
OCT 8 1954

STATEMENT BY LICENSED EMBALMER

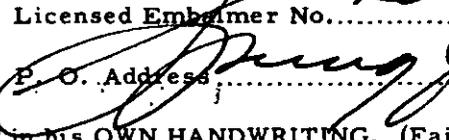
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....



Licensed Embalmer No..... 40

P. O. Address.....


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.