

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **673**BIRTH NO. _____ REG. DIST. NO. **86** PRIMARY REG. DIST. NO. **5328** Registrar's No. **3-1955**

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Franklin | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before institution). a. STATE Missouri b. COUNTY Franklin | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Eastburg, 5 Mi. E. 2th | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Eastburg | |
| c. LENGTH OF STAY (in this place) 1 yrs. | | d. STREET ADDRESS (If rural, give location) Rt #1, 5 Mi. S. on Rte 2th | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION At home of Miss Mesmore | | | |

| | | | | | |
|---|-------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Bell c. (Last) Smith | | | 4. DATE OF DEATH (Month) (Day) (Year) 2-2-1955 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Oct. 6, 1871 | 9. AGE (In years last birthday) 83 | IF UNDER 1 YEAR Months 3 Days 26 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Alto Pass, Ill. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | | | |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME Wilson Dearts | | 13b. MOTHER'S MAIDEN NAME Lena Ely Underwood | | 14. NAME OF HUSBAND OR WIFE | |
| 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. | | 17. INFORMANT'S SIGNATURE OR NAME Dr. M. M. Mesmore, Eastburg, Mo. ADDRESS | |

| | | | | | |
|---|--|---|--|---|--|
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Regenerative Heart Disease | | 20 yrs. | |
| | | DUE TO (c) | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardiac Decongestion | | 3 yrs. | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? 4222 YES <input type="checkbox"/> NO <input 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) (Min.) | | 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 **2-2-1955**, to **2-2-1955**, that I last saw the deceased alive on **2-2-1955**, and that death occurred at **1:30 p. m.**, from the causes and on the date stated above.

| | | | | | |
|--|--|---------------------------------|--|--------------------------------|--|
| 23a. SIGNATURE F. A. Seders, M.D. (Degree or title) | | 23b. ADDRESS Putnam, Mo. | | 23c. DATE SIGNED 2/3/55 | |
|--|--|---------------------------------|--|--------------------------------|--|

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 2-5-1955 | | 24c. NAME OF CEMETERY OR CREMATORY St. John's Cem. | | 24d. LOCATION (City, town, or county) (State) Franklin City, Ill. | |
| DATE REC'D BY LOCAL REG. 2/3/1955 | | REGISTRAR'S SIGNATURE W. C. Stone, Deputy Registrar | | 25. FUNERAL DIRECTOR'S SIGNATURE W. C. Stone | | ADDRESS Putnam, Mo. | |

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 10 1955

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 _____

Licensed Embalmer No. 3472

P. O. Address Cuba, 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.