

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12466**

FILED APR 26 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **170** PRIMARY REG. DIST. NO. **3033** Registrar's No. **65**

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Dallas</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Lebanon</b>	c. LENGTH OF STAY (In this place) <b>1 week</b>	c. CITY OR TOWN <b>Buffalo</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Nursing Home</b>		e. STREET ADDRESS (If rural, give location) <b>none</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b> b. (Middle) <b>H.</b> c. (Last) <b>Smith</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>April 19 55</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 1, 1877</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 21 YEARS: Hours <b>11</b> Days <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>New York State 1</b>	
13a. FATHER'S NAME <b>Henry Smith</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Lillian 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>-</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Lillian Smith</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Paralytic Stroke</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
		ANTECEDENT CAUSES DUE TO (b) <b>Cardiac Decompensation</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			<b>2 hrs.</b>	
		DUE TO (c) 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 <b>394 X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>Lebanon Missouri</b>
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 **Apr. 2, 1955**, to **Apr. 16, 1955**, that I last saw the deceased alive on **Apr 16, 1955**, and that death occurred **6:15 p m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. Bohrer</b> (Degree or title) <b>D.O. 2</b>	23b. ADDRESS <b>Lebanon, Missouri</b>	23c. DATE SIGNED <b>4/19/55</b>
24a. BURIAL, CREMATION, DISPOSAL (Specify) <b>Burial</b>	24b. DATE <b>Apr. 21-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Hope</b>
24d. LOCATION (City, town, or county) (State) <b>Liberty Mo</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>L. B. Jones</b>	
DATE REC'D BY LOCAL REG. <b>4-19-1955</b>	REGISTRAR'S SIGNATURE <b>Hella L. Gray</b>	ADDRESS <b>Buffalo Mo</b>

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

Received ..... 4-25-55 .....  
Laclede County Health Unit  
File No. .... 64 .....  
Date Filed..... 4-25-55 .....

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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..... *Marie B. Jones* .....

Licensed Embalmer No. 4322

P. O. Address. *Buffalo, N.Y.*

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.