

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22545

State File No.

BIRTH NO. _____ REG. DIST. NO. 154 PRIMARY REG. DIST. NO. 5575 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) ... a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY OR TOWN <u>RURAL WASHINGTON</u>		c. CITY OR TOWN <u>Independence</u>	
c. LENGTH OF STAY (in this place) <u>1 WK</u>		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 <u>Curtis Rest Home</u>		• STREET ADDRESS (If rural, give location) <u>501 South Hockess</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) <u>Harriett</u> b. (Middle) <u>May</u> c. (Last) <u>Smith</u>		<u>August-2-1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED <u>Widowed</u>	8. DATE OF BIRTH <u>Feb-25-1886</u>
9. AGE (In years last birthday) <u>69</u>		10. UNDER 1 YEAR <u>5</u> MONTHS <u>7</u> DAYS <u>7</u> HOURS <u>1</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Woodbine, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Brigham Reynolds</u>		13b. MOTHER'S MAIDEN NAME <u>Louella Coon</u>	
14. NAME OF HUSBAND OR WIFE <u>Joseph Smith - dec.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Elmer P. Smith</u>		ADDRESS <u>Indep. Mo.</u>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> ANTECEDENT CAUSES DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331x</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) (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 <u>July 10, 1955, to 15 July, 1955</u> , that I last saw the deceased alive on <u>15 July, 1955</u> , and that death occurred at <u>8:00 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or Title) <u>Sam D. Hooper, M.D.</u>		23b. ADDRESS <u>Grandview, Mo.</u>	
23c. DATE SIGNED <u>Aug 3-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug-4-1955</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove</u>		24d. LOCATION (City, town, or county) (State) <u>Independence Mo</u>	
DATE REC'D BY LOCAL REG. <u>8-11-55</u>		REGISTRAR'S SIGNATURE <u>Bylde A. Bridges</u>	
FUNERAL DIRECTOR'S SIGNATURE <u>Roland R. Speaks</u>		ADDRESS <u>Indep Mo</u>	

(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.....
Signature of Student Embalmer

Signed *R. Kenneth Peterson*

Licensed Embalmer No. *469*

P. O. Address *Indy, IN*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.