

THE DEPARTMENT OF HEALTH OF MISSOURI
 FILED OCT 16 1956 STANDARD CERTIFICATE OF DEATH

State File No. **36817**
 BIRTH NO. _____ REG. DIST. NO. **360** PRIMARY REG. DIST. NO. **6225** Registrar's No. **96**

1. PLACE OF DEATH a. COUNTY Vernon Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside limits of the city or town, give township) RFD-1 Nevada Mo		c. LENGTH OF STAY (in this place) 70 yrs.	c. CITY OR TOWN Nevada
d. FULL NAME OF HOSPITAL OR INSTITUTION R.F.D. #1 Nevada, Mo		e. STREET ADDRESS (If rural, give location) R.F.D. #1	

3. NAME OF DECEASED (Type or Print) a. (First) Mary	b. (Middle) Le Ota	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) Oct 4 - 1956
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5. SEX Fe.	6. COLOR OR RACE whit.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 12 - 1876	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 3 Days 22	IF UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Ferryport Indiana	12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Charles Hamruska	13b. MOTHER'S MAIDEN NAME Mary Jane Rockers	14. NAME OF HUSBAND OR WIFE W. E. Smith #1
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs Hatter Poland	ADDRESS Nevada Mo
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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 2 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute left ventricular failure		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (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	4342	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)
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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?
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22. I hereby certify that I attended the deceased from **10/4**, 19**56**, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **11:30** a.m., from the causes and on the date stated above.

23a. SIGNATURE Dora W. Jensen MD	(Degree or title) MD	23b. ADDRESS Nevada Mo	23c. DATE SIGNED 10/6/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct 8-56	24c. NAME OF CEMETERY OR CREMATORY Newton Cemetery	24d. LOCATION (City, town, or county) (State) Nevada Mo.
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DATE REC'D BY LOCAL REG. 10-8-56	REGISTRAR'S SIGNATURE Anna E. Ferris	25. FUNERAL DIRECTOR'S SIGNATURE Way Funeral Service	ADDRESS Mo Nevada Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

456

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 *H. H. Marmaduke*

Licensed Embalmer No. *2079*

P. O. Address *Nevada*

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.