

FILED DEC 31 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

40617

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1368

300
-56

Use only standard nomenclature in item 18. No symptoms written on this certificate. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Bushland Co.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph.</u>			Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		c. CITY OR TOWN <u>Norborne.</u> <u>0170</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 2</u>				Length of stay in lb <u>34 yrs. 2 day</u>		d. STREET ADDRESS (If outside, give location) <u>✓</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>MARY SMITH</u> Last <u>GOETTING</u>				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-24-1890.</u>	
9a. 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>shoe making</u>		11. BIRTHPLACE (City and state or country) <u>Norborne Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>C. J. Smith.</u>			
14. MOTHER'S MAIDEN NAME <u>Carrie Schefferdecker.</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>			
16. SOCIAL SECURITY NO. <u>None.</u>				17. INFORMANT Address <u>George C. Smith, Norborne, Missouri</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>Schizophrenia Catatonic Type.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>10-1-43 to 12-15-56</u> and last saw her ^{her} _{him} alive on <u>12-15-56</u> . Death occurred at <u>3:45 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>C. E. Corair</u>				22b. ADDRESS <u>M.D. State Hospital No. 2 St. Joseph Mo</u>		22c. DATE SIGNED <u>12-26-1956</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Remove</u>		23b. DATE <u>12/26/1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Norborne Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>Norborne Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Heston-Bowman St Joseph Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Dec 28, 1956</u>		26. REGISTRAR'S SIGNATURE <u>Ethel M. Allison</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 *William Spalding*.....

Licensed Embalmer No. *453*

P. O. Address *3195 105 St*

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