

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4033

STATE FILE NUMBER

FILED FEB 19 1957

Registration District No. 65 Primary Registration District No. 4116 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Chariton</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Chariton</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sumner</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sumner</u>		0210 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>None</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Franklin</u> Last <u>Smart</u>			4. DATE OF DEATH <u>Feb. 9th, 1957</u> Month <u>2</u> Day <u>9</u> Year <u>1957</u>		
5. SEX <u>Male</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>Oct 25-1898</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>16</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rt. Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>		11. BIRTHPLACE (City and state or country) <u>Sumner Mo. 0</u>	
13. FATHER'S NAME <u>Taylor Smart</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Beny</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>No</u>		17. INFORMANT <u>Mrs. Rose Smart, Sumner Mo.</u> Address	
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>Pneumonia - hypostatic.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Parkinson's disease.</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cochlear - mening.</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.) <u>No.</u>			
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>No.</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>2-4-53</u> to <u>2-9-53</u> and last saw her alive on <u>2-9-53</u> . Death occurred at <u>2-9-53, 10a. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>H. W. Dehnke M.D.</u> (Degree or title)			22b. ADDRESS <u>Franklin Mo.</u>		22c. DATE SIGNED <u>7/11/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 11-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakeside Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sumner Mo.</u>
24. FUNERAL DIRECTOR <u>Brothers James & Francis</u>		ADDRESS <u> </u>		25. DATE RECD. BY LOCAL REG. <u>2-15-1957</u>	26. REGISTRAR'S SIGNATURE <u> </u>

(Licensed Embalmer's Statement on Reverse Side)

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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..... *Blake Hedden*

Licensed Embalmer No. *50*

P. O. Address *Laclede*

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.