Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 13 1957

24269

STATE FILE NUMBER

Registration District No. 132 Primary Registration District No. 4203 Registrar's No. 146

1. PLACE OF DEATH a. COUNTY Grundy	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Grundy
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Galt — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Galt — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Home — Length of stay in 1b 25 yrs	d. STREET ADDRESS (If outside, give location) 0480 — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: HERBERT SAMUEL SMITH

4. DATE OF DEATH Month Day Year: 8-5-57

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-18-1880

9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (City and state or country): Sullivan Co Mo

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Samuel Smith

13b. MOTHER'S MAIDEN NAME: Elizabeth Crosson

14. NAME OF HUSBAND OR WIFE: Rosa Crawford Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 496-42-3570

17. INFORMANT: Mrs Rosa Smith — Address: Galt Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Massive Coronary Occlusion	2-4 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Chronic glomerulonephritis	2-5 years
DUE TO (c)	Chronic Myocarditis 420.1	3-5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 July 1957, to August 1957 and last saw her/him alive on Aug 5-1957. Death occurred at 4:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Sue Eitel D.O.

22b. ADDRESS: Galt Missouri

22c. DATE SIGNED: Aug 6-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 8-7-57

23c. NAME OF CEMETERY OR CREMATORY: Camp Ground Cem

23d. LOCATION (City, town, or county) (State): Osgood Mo

24. FUNERAL DIRECTOR ADDRESS: PK Payne & Son Galt Mo

25. DATE RECD. BY LOCAL REG.: 8-7-57

26. REGISTRAR'S SIGNATURE: Irene Farr

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with [illegible]. All diseases in Part I must be causally related.

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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 P K Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.