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FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

'57 027673
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 209

1. PLACE OF DEATH
a. COUNTY Callaway Co
b. CITY OR TOWN Fulton Mo — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #1 — Length of stay in Ib 227-19 Da

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Ralls Co
c. CITY OR TOWN Center — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS — (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Abe Middle M Last Smith

4. DATE OF DEATH Month August Day 25 Year 1957

5. SEX M **6. COLOR OR RACE** W **7.** MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ **8. DATE OF BIRTH** May 31 - 1874 **9. AGE** (In years if not birthday) 83 — 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) Stockman **10b. KIND OF BUSINESS OR INDUSTRY** Farm **11. BIRTHPLACE** (City and state or country) Ralls Co. Mo **12. CITIZEN OF WHAT COUNTRY?** U. S.

13a. FATHER'S NAME John H. Smith **13b. MOTHER'S MAIDEN NAME** Isabell Pike **14. NAME OF HUSBAND OR WIFE** —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) DK **16. SOCIAL SECURITY NO.** DK **17. INFORMANT** Mrs Howard Couch Address 2642 Oak, Quincy, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis
DUE TO (c) Organic (Senile) Brain Disease — 4 200 F

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Old fracture left hip. ?? Duodenal Ulcer.

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.) Patient found dead in bed by attendent
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 _____, to _____ and last saw her/him alive on _____
Death occurred at 12 00 Noon on 25 Aug. 1957 on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) S Douglas Downey M.D. **22b. ADDRESS** State Hospital #1 Fulton Mo **22c. DATE SIGNED** 25 Aug. 57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal **23b. DATE** Aug. 25-1957 **23c. NAME OF CEMETERY OR CREMATORY** DK **23d. LOCATION** (City, town, or county) Perry (State) Mo

24. FUNERAL DIRECTOR Clyde C. Wilkey **ADDRESS** Perry, Mo **25. DATE RECD. BY LOCAL REG.** Aug 25-1957 **26. REGISTRAR'S SIGNATURE** Maretta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Clyde C Wilkey

Licensed Embalmer No. 3826

P. O. Address Perry Mo.

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.