

S. Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35229  
STATE FILE NUMBER  
Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 336

FILED OCT 25 1957

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v. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Cole</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cole</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jefferson City</b>		c. CITY OR TOWN <b>Jefferson City</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>209 Cherry Street</b>		d. STREET ADDRESS (If outside, give location) <b>209 Cherry St</b>	
3. NAME OF DECEASED (Type or print) <b>Barbara Smith</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>16</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept-8-1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Germany</b>
13a. FATHER'S NAME <b>John Schneier</b>		13b. MOTHER'S MAIDEN NAME <b>Not Known</b>	14. NAME OF HUSBAND OR WIFE <b>John Smith</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>W.W. Smith, Jefferson City, Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>			<b>2 yrs</b>
DUE TO (c) <b>Generalized arteriosclerosis</b>			<b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Metastatic malignancy secondary to cancer of colon</b>			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.) <b>331X+H</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>12-21-56</b> to <b>10-16-57</b> and last saw <sup>her</sup> <del>him</del> alive on <b>10-16-57</b> Death occurred at <b>4:00 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Earl S. Long, M.D.</b>		22b. ADDRESS <b>Jeff. City, Mo.</b>	
22c. DATE SIGNED <b>10-18-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct-18-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson City, Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>Thorpe J Gordon, Jefferson City, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>21 Oct 1957</b>	26. REGISTRAR'S SIGNATURE <b>R.P. Norris, M.D.</b>

OCT 29 1957

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 *Joseph J. Jordan* .....  
Licensed Embalmer No. *1746* .....  
P. O. Address *.....* .....

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.