

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35580

STATE FILE NUMBER

FILED NOV 12 1957

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 633

1. PLACE OF DEATH a. COUNTY <i>Henry</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Henry</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Clinton</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Montrose, 042</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Clinton General Hosp 10 days</i>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <i>R#3</i>		
3. NAME OF DECEASED (Type or print) First <i>AMANDA</i> Middle <i>BELLE</i> Last <i>SMITH</i>				4. DATE OF DEATH Month <i>Nov.</i> Day <i>6</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>NOV. 2. 1876</i>	
9. AGE (In years last birthday) <i>81</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>7</i> Hours <i>—</i> Min. <i>—</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		11. BIRTHPLACE (City and state or country) <i>Henry Co Mo.</i>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Geo. V. Cameron</i>				14. MOTHER'S MARDEN NAME <i>Emilie Jones</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Mrs. Wayman Smith, 73</i> Address <i>Montrose Mo.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Insufficiency</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary Thrombosis</i>							<i>2 wks</i>
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>cholelithiasis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>
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 <i>—</i> Month, Day, Year a: m. <i>—</i> p. m. <i>—</i>							
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 <i>1951</i> to <i>11-6-57</i> and last saw her alive on <i>11-6-57</i> Death occurred at <i>1:00 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Sr. B. Hughes, M.D.</i>				22b. ADDRESS <i>Clinton Mo</i>		22c. DATE SIGNED <i>11-8-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Nov. 9, 1957</i>		<i>White Oak Cem</i>		<i>White, Mo Rural</i>	
24. FUNERAL DIRECTOR <i>H. D. Vansant, Clinton, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>11-8-57</i>		26. REGISTRAR'S SIGNATURE <i>Mildred Bigum</i>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare & Public Service

300 1-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

USE 6 I NOW

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..... *H. J. Tausant*

Licensed Embalmer No. *37*

P. O. Address *Bliston*

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.