

FILED DEC 6 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40725  
STATE FILE NUMBER

Registration District No. 196 Primary Registration District No. 3026 Registrar's No. 509

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Independence</b> <u>700</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>819 So. Main St.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>Blue Mills Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WINNIE</b> Middle <b>B.</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</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. 15, 1870</b>
10a. USUAL OCCUPATION (Give kind of work done of the last 12 months, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years by birthday) <b>87</b>
11. BIRTHPLACE (City and state or country) <b>Galien, Mich.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>George A. Blakeslee</b>		13b. MOTHER'S MAIDEN NAME <b>Lydia Olcott</b>	14. NAME OF HUSBAND OR WIFE <b>Stephen B. 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. <b>None</b>	17. INFORMANT <b>Miss Helen V. Smith</b> Address <b>Indep. Mo.</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) <u>Cerebro vascular</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Accident.</u> DUE TO (c) <u>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden Death</u> <u>Sudden Death</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atherosclerotic Heart Disease</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.) <b>332X</b>	
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			
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.)	
21. I attended the deceased from <u>May 28, 1956</u> to <u>Nov. 25, 1957</u> and last saw her <u>Nov 25, 1957</u> alive on <u>Nov 25, 1957</u> Death occurred at <u>12:50 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
22a. SIGNATURE <u>Chas. Grasso, M.D.</u> (Degree or title)		22b. ADDRESS <u>Independence, Mo</u>	22c. DATE SIGNED <u>11/26/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/27/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Galien, Mich. Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Galien, Michigan</b>
24. FUNERAL DIRECTOR <b>DIXON L. KEPLEY</b> Address <b>Indep. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-27-57</b>	26. REGISTRAR'S SIGNATURE <u>Jane K. Craig</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

58

DEC 4 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 *Walter L. Hayes* .....  
Licensed Embalmer No. *4225* .....  
P. O. Address *Indep 740* .....

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.