

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009703
STATE FILE NUMBER

FILED APR 15 1958

Registration District No. 138 Primary Registration District No. 4220 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY <u>Hickory</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u> <u>0430</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wheatland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Wheatland</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>North Wheatland</u> Length of stay in 1b <u>59 years</u>		d. STREET ADDRESS (If outside, give location) <u>North Wheatland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>LEONA</u> Middle Last <u>Smith</u>			4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3-1878</u>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE (In years last birthday) <u>79</u> FUNDING YEAR Months <u>11</u> Days <u>2</u> IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>Sullivan County, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>James Olmstead</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Miller</u>	14. NAME OF HUSBAND OR WIFE <u>Alonza Smith</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Cecil Wolf - Wheatland, Mo</u>
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>Coronary Thrombosis Suddenlly</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>shrubbery</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>H201</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 _____ Month, Day, Year a.m. _____ p.m. _____			
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 <u>Oct 1949</u> to <u>April 5, 1958</u> and last saw her alive on _____ Death occurred at <u>9:18</u> <u>A</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. E. Buggs, D.O.</u>		22b. ADDRESS <u>Wheatland, Mo</u>	22c. DATE SIGNED <u>4-6-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>April 7-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Summer Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Wheatland, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Libert Hetherington - Wheatland, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-7-1958</u>	26. REGISTRAR'S SIGNATURE <u>May Johnson</u>

(Licensed Embalmer's Statement on Reverse Side)

300
1-57
0
1
114
0

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.

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 *Chas. Silberkattaway*

Licensed Embalmer No. *4267*
P. O. Address *Wheatland, W.*

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.