

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019274
STATE FILE NUMBER

FILED JUN 3 1958

Registration District No. 278 Primary Registration District No. 4415 Registrar's No. 86

300
1-57

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLARKSVILLE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CLARKSVILLE</u> 0820 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RIVER ROAD</u>		Length of stay in 1b <u>48 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>RIVER ROAD</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE ROBERT SMITH</u>			4. DATE OF DEATH Month Day Year <u>5 26 58</u>			
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-5 1880</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during rest of working life, even if retired) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>	11. BIRTHPLACE (City and state or country) <u>LINCOLN COUNTY, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>IRA C SMITH</u>	13b. MOTHER'S MAIDEN NAME <u>INDIA THOMPSON</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>489-36-3751</u>	17. INFORMANT Address
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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>cerebrovascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>generalized Arteriosclerosis</u>	
	DUE TO (c) <u>331X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>generalized exfoliative dermatitis</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.)
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20c. TIME OF INJURY Hour 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
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21. I attended the deceased from <u>15 Jan. 1958</u> , to <u>26 May 58</u> and last saw him alive on <u>25 May 58</u> Death occurred at <u>1140 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>John H. Hood, M.D.</u>	22b. ADDRESS <u>Clarksville, Mo.</u>	22c. DATE SIGNED <u>29 May 58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY-30-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE MO</u>
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24. FUNERAL DIRECTOR <u>CARROLL COLLIER</u>	ADDRESS <u>CLARKSVILLE MO</u>	DATE RECD. BY LOCAL REG. <u>May 30-1958</u>	25. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
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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.

JUL 8 8 1958

JUN 27 1958

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

Licensed Embalmer No.....

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.