

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028581  
STATE FILE NUMBER

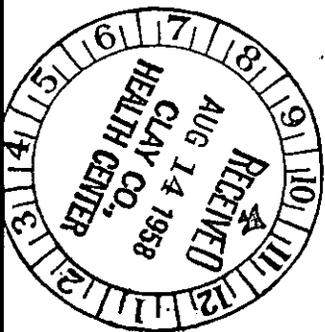
FILED AUG 25 1958 Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 65

1. PLACE OF DEATH a. COUNTY <b>Clay</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>		
b. CITY OR TOWN <b>Rural</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Excelsior Springs</b>		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>2 mi. S. Ex. Springs</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>2 mi. S. Ex. Springs</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CLYDE H SMITH</b>			4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1881</b>	9. AGE (In years last birthday) <b>77</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Adv. Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Advertising Agency</b>	11. BIRTHPLACE (City and state or country) <b>Long Island, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Daniel Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Della 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>496-09-7830A</b>	17. INFORMANT Address <b>Della Smith, Rt. #1, Excelsior Springs, 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) <b>Congestive Heart Failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>sev. mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b>					<b>sev. yrs.</b>
DUE TO (c) <b>4500</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
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 <b>4/12/57</b> to <b>8/1/58</b> and last saw her alive on <b>8/1/58</b> Death occurred at <b>1:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Do not write title) <i>[Signature]</i>			22b. ADDRESS <b>M. D. Excelsior Springs, Mo.</b>		22c. DATE SIGNED <b>8/5/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-4-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Excelsior Springs, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Prichard Funeral Home, Inc. Excelsior Springs, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>8/6/58</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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.

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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 Ludell Jarman

Licensed Embalmer No. 4589  
P. O. Address Excelsior Springs

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.