

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029759  
STATE FILE NUMBER

FILED SEP 5 1958 Registration District No. 239 Primary Registration District No. 4356 Registrar's No. 22

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

3. NAME OF DECEASED (Type or print) <b>Emmaline Smith</b> <i>First Middle Last</i>			4. DATE OF DEATH <b>Aug. 20 1958</b> <i>Month Day Year</i>		
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5. SEX <b>female</b>	6. COLOR OR RACE <b>cauo.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1861</b>	9. AGE (In years last birthday) <b>96</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Saline County Ill. /</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13. FATHER'S NAME <b>John Seets</b>	14. MOTHER'S MAIDEN NAME <b>Besheba Mills</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Sallie Gibbs Parma Mo.</b>
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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) <b>Cardiac Decompensation</b> <b>Old Age</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Old Age</b> DUE TO (c) <b>4344</b>		INTERVAL BETWEEN ONSET AND DEATH
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 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 **8 P.M. 1958** to **Aug 20, 1958** and last saw her <sup>her</sup> ~~him~~ alive on **Aug 20, 1958**  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or Attie.) <b>Dr. Gresh W. Hunted, M.D.</b>	22b. ADDRESS <b>Parma, Mo.</b>	22c. DATE SIGNED <b>8/28/58</b>
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23a. BURIAL, CREMATION, REPOSING (Type) <b>burial</b>	23b. DATE <b>Aug. 24, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park,</b>	23d. LOCATION (City, town, or county) (State) <b>Malden Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Watkins Funeral Service Parma Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8/28/58</b>	26. REGISTRAR'S SIGNATURE <b>Dr. Gresh W. Hunted, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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DATE RECEIVED SEP 3 1958  
NEW MADRID CO. HEALTH CENTER  
P. J. S.

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.....  
*Earl C. Watkins*

Licensed Embalmer No. 470

P. O. Address.....  
*Clinton*

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.