

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035310  
STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 371 Primary Registration District No. 6259 Registrar's No. 16

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EAST BENTON</u>		c. CITY OR TOWN <u>FORDLAND</u> <u>1420</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FORDLAND RT 1</u>		d. STREET ADDRESS (If outside, give location) <u>ROUTE 1</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES WALTER SMITH</u>			4. DATE OF DEATH Month Day Year <u>Sept 18 1958</u>		
---	--	--	---	--	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-7-1913</u>	9. AGE (In years last birthday) <u>44</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	---------------------------------------	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>WEBSTER CO MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	-----------------------------------	--	--

13a. FATHER'S NAME <u>OTTO SMITH</u>	13b. MOTHER'S MAIDEN NAME <u>ELLA LAYNE</u>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

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.	17. INFORMANT Address <u>Mrs Ella Smith, Fordland mo RT 1</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>Broncho-pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Congestive Heart Failure</u>		
DUE TO (c) <u>4341</u>		
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 <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>Jan 14, 1945</u> to <u>Sept 18, 58</u> and last saw him alive on <u>Sept. 13, 1958</u> Death occurred at <u>7:00 P.M. SEPT 18, 1958</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <u>D.R. Schultz, Sec. 2</u>	22b. ADDRESS <u>Fordland Mo.</u>	22c. DATE SIGNED <u>9/23/58</u>
---	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT-21-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CASS CHAPEL CEMETERY</u>	23d. LOCATION (City, town, or county) <u>WEBSTER CO MISSOURI</u>
--	----------------------------------	---	---

24. FUNERAL DIRECTOR <u>Kelley-Ferrell-CONNOR</u>	ADDRESS <u>FORDLAND, MO</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 23-1958</u>	26. REGISTRAR'S SIGNATURE <u>Opal M. Good</u>
--	--------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

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 *Wm K Ferrell* .....

Licensed Embalmer No. *4910* .....

P. O. Address *Rayesville, N* .....

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.