Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-038836
STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 27 Primary Registration District No. 3002 Registrar's No. 163

1. PLACE OF DEATH
a. COUNTY: BATES
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): BUTLER - Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 7 WILSON Length of stay in Hospital: 24 HRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: BATES
c. CITY OR TOWN: BUTLER - Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 607 7-WILSON Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First CLOA Middle L. Last SMITH
4. DATE OF DEATH: Month NOV Day 27 Year 1958
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: AUG-8-1884
9. AGE (In years last birthday): 74 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): HOMEMAKER -
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): LINN CO MO
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: ROBERT LANE
13b. MOTHER'S MAIDEN NAME: NARCY MURREL
14. NAME OF HUSBAND OR WIFE: O.C. SMITH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 495-42-7683
17. INFORMANT: O.C. Smith Address: Butler, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Left Side heart failure — 3 months.
DUE TO (c) metastatic invasion of lungs by Sarcoma — 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Primary Sarcoma of Cervix 171X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 July 8, 1958, to Nov. 26 '58 and last saw her alive on Nov. 26, 1958
Death occurred at 5:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): L. S. Lafferty, M.D.
22b. ADDRESS: Wynes Bldg, Butler, Mo
22c. DATE SIGNED: Nov. 28/58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 11-30-58
23c. NAME OF CEMETERY OR CREMATORY: OAKHILL -
23d. LOCATION (City, town, or county) (State): BUTLER MO

24. FUNERAL DIRECTOR: CULVER-UNDERWOOD - ADDRESS: BUTLER MO
25. DATE RECD. BY LOCAL REG.: NOV. 28-1958
26. REGISTRAR'S SIGNATURE: Kendall Kenny

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

DEC 11 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 John G Underwood

Licensed Embalmer No. 3585

P. O. Address BUTLER M

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.