

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045313
STATE FILE NUMBER

FILED DEC 16 1958 Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 446

5. 300
1-57

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN FARMINGTON 0940
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BONNE TERRE HOSPITAL		Length of stay in 1b 4: 00	d. STREET ADDRESS (If outside, give location) SPRUCE STR
3. NAME OF DECEASED First Middle Last MARY EILEEN SMITH			4. DATE OF DEATH Month Day Year Dec 9 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) 6 CHESTER ILL
13a. FATHER'S NAME CHARLES C YATES		13b. MOTHER'S MAIDEN NAME JOSEPHINE BELKEN	14. NAME OF HUSBAND OR WIFE CHARLES SMITH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Charles Smith, Farmington, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Essential Hypertension			INTERVAL BETWEEN ONSET AND DEATH one yr.
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 1955 to 12/8/58 and last saw her alive on 12-8-58 Death occurred at 5 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R. A. Huckstep M.D.		22b. ADDRESS Farmington, Mo.	22c. DATE SIGNED 12/9/58
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE Dec. 12, 1958	23c. NAME OF CEMETERY OR CREMATORY Crystal City Catholic Cem	23d. LOCATION (City, town, or county) (State) Crystal City Mo.
24. FUNERAL DIRECTOR ADDRESS Cozean Funeral Home		25. DATE RECD. BY LOCAL REG. Dec. 9, 1958	26. REGISTRAR'S SIGNATURE Ether Rudloff

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *C. J. Cozeman*
Licensed Embalmer No. *4084*
P. O. Address *Farrington*

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.