

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000222  
STATE FILE NUMBER

FILED JAN 19 1958 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Jefferson City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U. of Mo Med Center</u>			Length of stay in lb <u>32</u>		d. STREET ADDRESS (If outside, give location) <u>2202 Mulberry</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clifton Edward Smith</u>				4. DATE OF DEATH Month Day Year <u>1 12 1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-11-11</u>		9. AGE (In years last birthday) <u>47</u>	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) <u>Machine Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maintenance Fayette Co. Ky.</u>		11. BIRTHPLACE (City and state or country) <u>Fayette Co. Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John C. Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Annietta Frisloe</u>			14. NAME OF HUSBAND OR WIFE <u>Mary Belle Smith</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>407-10-4855</u>		17. INFORMANT <u>Hosp. Tal chart Columbia, Mo.</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>GASTROINTESTINAL HEMORRHAGE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ACUTE MONOCYTTIC LEUCEMIA</u>							10 months	
DUE TO (c) <u>2042</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>BRONCHOPNEUMONIA, EMPYEMA, LEFT BRONCHOPLEURAL FISTULA</u>							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>12-11-58</u> to <u>1-12-59</u> and last saw him alive on <u>1-12-59</u> Death occurred at <u>4:42 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Diane Burkardt, M.D.</u>				22b. ADDRESS <u>U. of Mo. Medical Center, Columbia</u>		22c. DATE SIGNED <u>1-12-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>1-14-59</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Woodlawn Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson City Mo</u>			
24. FUNERAL DIRECTOR <u>Victor B. Massey</u>		ADDRESS <u>Jefferson City Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 13 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

VS FEB 2 - 1959

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 *Victor Buescher* .....

Licensed Embalmer No. *370* .....

P. O. Address *J. M. 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.