

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006663  
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 277 Primary Registration District No. 5949 Registrar's No. 15

300  
-57

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

3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>-</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>23</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 15 1876</b>		9. AGE (In years last birthday) <b>82</b> IF UNDER 1 YEAR Months <b>6</b> Days <b>22</b> IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (City and state or country) <b>Pike Co. MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>

13a. FATHER'S NAME <b>JAMES R. Smith</b>		13b. MOTHER'S MAIDEN NAME <b>MARGARET Hubbard</b>		14. NAME OF HUSBAND OR WIFE <b>Lillie Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mrs Courtney Cooper</b> Address <b>50 Bowling Green</b>	

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>CEREBRAL HEMORRHAGE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOSCLEROSIS</b>	<b>YRS</b>
	DUE TO (c) <b>-</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>NO ONE</b>		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 <b>-</b> Month, Day, Year <b>-</b> a.m. <b>-</b> p.m. <b>-</b>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK OR 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 **1947** to **-** and last saw <sup>when</sup> him alive on **JAN 1959**  
Death occurred at **9.30** p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>W. B. ...</b>	22b. ADDRESS <b>Bowling Green Mo</b>	22c. DATE SIGNED <b>24 Feb 59</b>
---	--------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>	23b. DATE <b>Feb. 25</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ANTIOCH</b>	23d. LOCATION (City, town, or county) (State) <b>Pike Co MO</b>
---	--------------------------	---	---

24. FUNERAL DIRECTOR <b>Grace Bankhead</b> ADDRESS <b>Bowling Green Mo</b>	25. DATE RECD. BY LOCAL REG. <b>2-26-59</b>	26. REGISTRAR'S SIGNATURE <b>Gill Robinson</b>
--	---	--

(License of Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Harold C. Kirk* .....

Licensed Embalmer No. *4597* .....

P. O. Address *Bowling Green* .....

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.