

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008617

STATE FILE NUMBER

FLED APR 14 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 105

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kennett</u> <u>0352</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Hospital No 1</u>		Length of stay in 1b <u>4Yrs, 2Mo</u>	d. STREET ADDRESS (If outside, give location) <u>Unknown</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle _____ Last <u>Smith</u>			4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1959</u>		
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5. SEX <u>Male</u> <u>2</u>	6. COLOR OR RACE <u>Negro</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>July 10, 1914</u>	9. AGE (In years last birthday) <u>44</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Archie Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Arthula ???</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>State Hospital No. 1, Fulton, Mo.</u> Address _____
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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>Cerebro-vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</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.) <u>331x</u>
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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 <u>St. Hosp.</u>	COUNTY _____ STATE _____
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21. Attended the deceased from <u>1/17/1955</u> to <u>4-9-59</u> and last saw her/him alive on <u>4-9-59</u> Death occurred at <u>1:45 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	22a. SIGNATURE <u>Erwin Leonhardt, M.D.</u>	22b. ADDRESS <u>St. Hospital No. 1</u>	22c. DATE SIGNED <u>4-9-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4/10/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>
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24. FUNERAL DIRECTOR <u>Robt. D. Johnston</u>	ADDRESS <u>Columbia Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>April-10-1959</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
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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

Licensed Embalmer No.....

P. O. Address.....

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.