

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008679

STATE FILE NUMBER

FILED MAR 25 1959

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 56

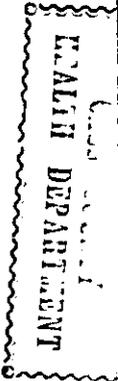
300  
-57

Health,  
Welfare  
Public  
Service

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Cass</u>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>                       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Harrisonville</u>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Harrisonville</u> <u>0198</u>                             |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Suburban</u>  |                                  | Length of stay in lb<br><u>5 yr.</u>  | d. STREET ADDRESS (If outside, give location)<br><u>Suburban</u>             |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>BENJAMIN FRANKLIN SMITH</u>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>Mar 14 1959</u>                     |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 11-1888</u>                                      |
| 9. AGE (In years last birthday)<br><u>70</u>  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Harmon</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   | 11. BIRTHPLACE (City and state or county)<br><u>St. Clair Co. Mo</u>         |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                  | 13a. FATHER'S NAME<br><u>Berry Smith</u>  |  |
| 13b. MOTHER'S MAIDEN NAME<br><u>Susan Ann Hall</u>  |                                  | 14. NAME OF HUSBAND OR WIFE<br><u>Edna Carl Smith</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  | 17. INFORMANT<br><u>Walter Smith</u> Address <u>Garden City Mo</u>           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA, Neck, Bilateral</u><br>DUE TO (b) <u>CARCINOMA, GINGIVAE, LOWER, Bilateral</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>144x</u> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 1/2 YEARS</u><br><u>2 1/2 YEARS</u> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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<br>Hour <input type="checkbox"/> Month, Day, Year<br>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>7 PM 1957</u> to <u>MAR. 14 1959</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>MAR. 10, 1959</u><br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |  |
| 22a. SIGNATURE<br><u>Dr. J. Stargow MD</u> (Degree or title)  |                                  | 22b. ADDRESS<br><u>Harrisonville Mo</u>   | 22c. DATE SIGNED<br><u>17 MAR 1959</u>                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE<br><u>Mar 17-1959</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Orient Cemetery</u>                 |
| 23d. LOCATION (City, town, or county) (State)<br><u>Harrisonville Mo</u>  |                                  | 24. FUNERAL DIRECTOR<br><u>Runnenburger Harrisonville Mo</u>  |  |
| 25. DATE RECD. BY LOCAL REG.<br><u>3-18-59</u>  |                                  | 26. REGISTRAR'S SIGNATURE<br><u>Mrs. Gray Sebrer</u>  |  |

(Licensed Embalmer's Statement on Reverse Side)



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 Frank E. Rummelburger 3<sup>rd</sup>, Student Embalmer No. 568 working under my personal supervision.

Student Frank E. Rummelburger 3<sup>rd</sup> Signed James R. Phillips  
Signature of Student Embalmer

Licensed Embalmer No. 4641

P. O. Address Harrisonville

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.