

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010608  
STATE FILE NUMBER

FILED APR 8 1959 Registration District No. 311 Primary Registration District No. 4456 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <b>St Clair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Henry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Appleton City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Montrose</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Ellett Hospital</b> Length of stay in 1b <b>1 day</b>		d. STREET ADDRESS (If outside, give location) <b>in Montrose</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Smith</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1959</b>		
--	--	--	---	--	--

5. SEX <b>Female</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>9-24-1877</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	--	-----------------------------------	---	--	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Hopkins Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	-----------------------------------	--	--

13a. FATHER'S NAME <b>William Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Eliza Mackentash</b>	14. NAME OF HUSBAND OR WIFE <b>Ed Smith</b>
---	---	---

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.	17. INFORMANT <b>Lewis Smith</b> Address <b>Montrose Mo</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>Myocardial infarction, acute</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	<b>4301</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 a.m. p.m. Month, Day, Year	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Appleton City</b> COUNTY <b>Henry</b> STATE <b>Mo</b>
--	--	---

21. I attended the deceased from **31 Mar 59** to **1 Apr 59** and last saw her alive on **1 Apr 59**  
Death occurred at **7057 a** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>W. Ellett M.D.</b> (Degree or title)	22b. ADDRESS <b>Appleton City</b>	22c. DATE SIGNED <b>1 Apr 59</b>
--	-----------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>4-3-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Montrose cemetery</b>	23d. LOCATION (City, town, or county) <b>Montrose Mo</b> (State)
---	---------------------------	---	--

24. FUNERAL DIRECTOR <b>Sickman-Dunning</b> ADDRESS <b>Clinton Mo</b>	25. DATE RECD. BY LOCAL REG. <b>April 3/1959</b>	26. REGISTRAR'S SIGNATURE <b>Chas. Atney</b>
---	--	--

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 *Robert L. Dunning*

Licensed Embalmer No. *710*

P. O. Address *Clinton, Mo.*

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.