

Dr. Turner

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017404

STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 569

300
1-57

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOWELL	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN WEST PLAINS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		d. STREET ADDRESS (If outside, give location) LEBO ROUTE	
3. NAME OF DECEASED (Type or print) First Middle Last CLAUDE C. SMITH		4. DATE OF DEATH Month Day Year JUNE 8 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 5 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) HENDERSON, ARK.
13a. FATHER'S NAME FRANK SMITH		13b. MOTHER'S MAIDEN NAME NETTIE TRACY	14. NAME OF HUSBAND OR WIFE LAULA SMITH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ?	17. INFORMANT Address MRS. C.C. SMITH WEST PLAINS, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE OF LEFT VENTRICLE DUE TO (b) INFARCTION OF MYOCARDIUM DUE TO ARTEROSCLEROTIC CORONARY THROMBOSIS DUE TO (c) THROMBOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH INSTANT 9 DAYS.
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <input type="checkbox"/> 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>4-20-51</u> , to <u>6-8-59</u> and last saw ^{XX} him ^{live on} <u>6/8/59</u> Death occurred at <u>11:35 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Blennott</i>		22b. ADDRESS M.D. 609 Cherry-Springfield, Mo.	
22c. DATE SIGNED 6-9-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 6/10/59	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or country) (State) WEST PLAINS, MO.	
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 6-11-59	
26. REGISTRAR'S SIGNATURE <i>Offie E. Melton</i>			

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 *A. H. MacCorm*

Licensed Embalmer No. *2727*

P. O. Address *Springfield*

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.