

8 Dr. Hahn

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017405

STATE FILE NUMBER

300  
1-57

JUN 15 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 562

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>TEXAS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>CABOOL</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>		Length of stay in lb <b>2 WKS.</b>	d. STREET ADDRESS <b>1070 6</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES LEROY SMURR</b>			4. DATE OF DEATH Month Day Year <b>JUNE 6 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>MAY 9 1890</b>
9. AGE (In years last birthday) <b>69</b>		FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACIST</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Independence, MO.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>JOHN M. SMURR</b>	13b. MOTHER'S MAIDEN NAME <b>ADALINE STONE</b>
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>
17. INFORMANT Address <b>MRS. W.H. SPEAKER SPRINGFIELD, 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>Brain tumor (type not as yet known)</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b> 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)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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"/>		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 <b>4-8-59</b> , to <b>6-6-59</b> and last saw him alive on <b>6/6/59</b> Death occurred at <b>10:30 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) <i>[Signature]</i> M.D.		22b. ADDRESS <b>609 Cherry-Springfield, Mo.</b>	22c. DATE SIGNED <b>6-8-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6/9/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>	23d. LOCATION (City, town, or county) (State) <b>WEST PLAINS, MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>ELLIOTT-GENTRY FUNERAL HOME, CABOOL, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6-10-59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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 *H. McQuinn* .....

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.