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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021835

FILED JUL 7 1959

Registration District No. 146

Primary Registration District No. 3026

STATE FILE NUMBER 293
Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Independence		c. CITY OR TOWN Independence	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. Hosp.		Length of stay in 1b 2yr. 9mos.	
700 g. STREET ADDRESS R.R.#1, Hines Road		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First TERESA Middle KAY Last SMITH			4. DATE OF DEATH Month June Day 25 Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1956	9. AGE (In years last birthday) 2 yrs. 9	10. IF UNDER 1 YEAR Months Days	11. 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) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Independence, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Carl Smith	13b. MOTHER'S MAIDEN NAME Elsie Guiley	14. NAME OF HUSBAND OR WIFE --
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mr. Carl Smith, R.R.#1, Hines Road.
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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) Pending further investigation		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)		

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.)
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20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____	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
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21. I attended the deceased from 9/11/56 to 5/26/59 and last saw her alive on 5/26/59 Death occurred at 5 AM on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Name or title) R. B. Bough, M.D.	22b. ADDRESS 317 W. Kansas - Independence	22c. DATE SIGNED 6/26/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 28, 1959	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION (City, town, or county) (State) East Truman Road
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24. FUNERAL DIRECTOR OTT & MITCHELL, Indep., Mo.	25. DATE RECD. BY LOCAL REG. 6-28-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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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 *Jason T. White*

Licensed Embalmer No. *4925*

P. O. Address *Orlando, FL*

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.