

Dept. Health,
uc., & Welfare
J. S. Public
Health Service

FILED VS OCT 21 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-038651

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 4502 Registrar's No. 92

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Puxico</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Puxico</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>1030</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 19 1897</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Asherville Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Joda Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Rosa Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes world war #1</u>		16. SOCIAL SECURITY NO. <u>366-18-0974</u>	17. INFORMANT <u>Bertha Smith Puxico Mo</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA Right Lung</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>
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) <u>163X</u>					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. _____					
20d. INJURY OCCURRED WHILE AT WORK <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>6-10-59</u> to <u>10-5-59</u> and last saw ^{him} alive on <u>10-5-59</u> Death occurred at <u>8:30</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Dress or title) <u>Vernon H. Morgan</u>			22b. ADDRESS <u>Puxico Mo</u>		22c. DATE SIGNED <u>10-7-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 7. 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Puxico</u>		23d. LOCATION (City, town, or county) (State) <u>Puxico Mo</u>
24. FUNERAL DIRECTOR <u>Glad Morgan</u>		ADDRESS <u>Puxico Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-17-59</u>	26. REGISTRAR'S SIGNATURE <u>Anita M. Danner, Dep. Reg</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949. 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.

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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 *W^m H. Morgan*

Licensed Embalmer No. *4640*

P. O. Address *Advances, 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.