

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038885

FILED VS NOV 17 1959

Registration District No. 032 Primary Registration District No. _____ Registrar's No. 73

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Bollinger County</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>Lutesville</u>		Length of stay in 1b <u>2 wks.</u>	c. CITY OR TOWN <u>Advance</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bond Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>Rt #1</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Vara</u> Middle <u>Bell</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1959</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1911</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>	11. BIRTHPLACE (City and state or country) <u>Near Oak Ridge, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Albert C. Ford</u>	13b. MOTHER'S MAIDEN NAME <u>Unncia Rebecca Sheppard</u>	14. NAME OF HUSBAND OR WIFE <u>John Henry Smith</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>HARLAN SMITH</u> Address <u>ADVANCE, Mo.</u>
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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) <u>Circulatory failure.</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral thrombosis.</u>	
	DUE TO (c) <u>Arteriosclerosis.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from 10-7-59 to 10/17/59 and last saw her live on 10/17/59
Death occurred at 12:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John F. Wiggins DO</u> (Degree or title)	22b. ADDRESS <u>Lutesville Mo</u>	22c. DATE SIGNED <u>10/20/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>	23d. LOCATION (City, town, or county) <u>Jackson, Mo.</u> (Site)
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24. FUNERAL DIRECTOR <u>W. H. Morgan, Advance, Mo.</u> ADDRESS <u>11-10-59</u>	25. DATE RECD. BY LOCAL REG. _____	26. REGISTRAR'S SIGNATURE <u>Mr. Buford Crider</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
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 _____

Advance,

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.