

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS FEB 9 1960**

**-60-002932**

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 22

STATE FILE NUMBER

|   |  |   |  |  |  |  |                |
|---|--|---|--|--|--|--|----------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Randolph</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>e. STATE <u>Missouri</u> b. COUNTY <u>Rand.</u> |  |  |                |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Moberly</u>   |  | Length of stay in 1b<br><u>1 week</u>   |  | c. CITY OR TOWN <u>Cairo</u>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Woodland Hospital</u>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><u>6 Ml. E of Cairo</u>   |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Ewing Jay Smith</u>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>1/28/60</u>   |  |  |                |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u>       | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>12/8/79</u>   | 9. AGE (last birthday)<br><u>80</u>        | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>ferming</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><u>Iowa</u>  |  | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |                |
| 13a. FATHER'S NAME<br><u>George A. Smith</u>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Holder</u>                                      |  | 14. NAME OF HUSBAND OR WIFE<br><u>none</u> |  |                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |  | 16. SOCIAL SECURITY NO.<br><u>486 42 0268</u>   |  | 17. INFORMANT<br><u>George Bean</u>  |  | Address<br><u>RFD, Madison, Mo.</u>  |                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis with left hemiplegia</u>   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hours</u>  |                |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Arteriosclerotic cerebral vascular disease</u>  |  |   |  |  |  | unknown  |                |
| DUE TO (c)  |  |   |  |  |  |  |                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Epilepsy due to arteriosclerosis - 2 years.</u>   |  |   |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>Month, Day, Year   |  |   |  |  |  |  |                |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>July 2, 1958</u> , to <u>Jan. 28, 1960</u> and last saw <sup>her</sup> him alive on <u>Jan. 28, 1960</u><br>Death occurred at <u>3:30 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)<br><u>Clarence Clobs</u>   |  |   |  | 22b. ADDRESS<br><u>317 Virginia Avenue Moberly, Missouri</u>   |  | 22c. DATE SIGNED<br><u>1/29/60</u>   |                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>1/30/60</u>            | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hickory Grove Cem.</u>   |  | 23d. LOCATION (City, town, or county) (State)<br><u>E. of Cairo, Mo.</u>   |  |  |                |
| 24. FUNERAL DIRECTOR<br><u>Merion F. Million</u>  |  | ADDRESS<br><u>Moberly, Mo.</u>  |  | 25. DATE RECD. BY LOCAL REG.<br><u>1-30-60</u>   |  | 26. REGISTRAR'S SIGNATURE<br><u>Jauber</u>   |                |

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Marion E. Milligan

Licensed Embalmer No. 3957

P. O. Address Moberly, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.