

MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005416

FILED VS. MAR. 8 1960 53 Primary Registration District No. 3010 Registrar's No. 90

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u> Length of stay in 1b <u>3 wks.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>NEW MADRID</u> c. CITY OR TOWN <u>FORTAGEVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>104 E. 5th Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FAIMIE</u> <u>SMILLEY</u>			4. DATE OF DEATH Month Day Year <u>JAN.</u> <u>25</u> <u>1960</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-1875</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>teaching school</u>		11. BIRTHPLACE (City and state or country) <u>CAPE GIRARDEAU, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>RUSSELL JUDEN</u>		13b. MOTHER'S MAIDEN NAME <u>ANNIE MILLER</u>		14. NAME OF HUSBAND OR WIFE <u>STEVE SMILLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>499-24-7437</u>		17. INFORMANT Address <u>Allen Swilley</u> <u>Portageville, Mo.</u>			
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>Hepatic Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Biliary Cirrhosis</u> DUE TO (c) <u>Gall Stones</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>6 mos.</u> <u>many years</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 checked="" 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.)					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
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>1/2/60</u> to <u>1/25/60</u> and last saw her/him alive on <u>1/25/60</u> Death occurred at <u>2:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>C.P. McGinty, M.D.</u>			22b. ADDRESS <u>1912 Broadway Cape Gir., Mo.</u>		22c. DATE SIGNED <u>3/1/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fortageville</u>	23d. LOCATION (City, town, or county) (State) <u>Fortageville, Missouri</u>				
24. FUNERAL DIRECTOR ADDRESS <u>DE LITTLE FUNERAL HOME FORTAGEVILLE, MO</u>		25. DATE RECD. BY LOCAL REG. <u>3-2-1960</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</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 by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Joseph A. DeLoe
Licensed Embalmer No. 4781

P. O. Address Pragueville

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.