

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007182

FILED VS. FEB 16 1960

187 Primary Registration District No. 3040 Registrar's No. 19

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Livingston	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe		Length of stay in 1b 50 yrs.	c. CITY OR TOWN Chillicothe Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1015 Locust		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1015 Locust Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HENRY Middle MARVIN Last SMITH			4. DATE OF DEATH Month Feb. Day 6, Year 1960	
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months _____ Days _____	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) Postal Clerk	10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	11. BIRTHPLACE (City and state or country) No Record	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME William A. Smith	13b. MOTHER'S MAIDEN NAME Margaret E. Skinner	14. NAME OF HUSBAND OR WIFE Rosa Haines Smith
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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 Mrs. W. M. Smith; 1015 Locust	Address
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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) Bilateral lobar pneumonia Chillicothe, Mo. 18 hrs		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Influenza & secondary pulmonary infection	36 hrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility & arteriosclerotic heart disease	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
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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 July 1954 to Feb 6, 1960 and last saw him alive on Feb 5, 1960
Death occurred at 9:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William R. Fair, M.D.	22b. ADDRESS Chillicothe Mo	22c. DATE SIGNED 2/9/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-9-60	23c. NAME OF CEMETERY OR CREMATORY Resthaven	23d. LOCATION (City, town, or county) (State) Chillicothe, Missouri
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24. FUNERAL DIRECTOR Norman Funeral Home Chillicothe, Missouri	ADDRESS	25. DATE RECD. BY LOCAL REG. 2/9/60	26. REGISTRAR'S SIGNATURE Frances B Neill
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 26 1960

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

E. R. Rawson

Licensed Embalmer No. _____

P. O. Address 4036

Chillicothe,

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.