

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018473

FILED VS JUN 13 1960

042

1000

635

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 4 months	c. CITY OR TOWN Agency Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunny Slope Nursing Home 3225 S. 11th St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last OSCAR C. SMEDLEY			4. DATE OF DEATH Month Day Year June 5, 1960		
---	--	--	---	--	--

5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/1/1873	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	-------------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer	10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (City and state or country) Buchanan County, Mo.	12. CITIZEN OF WHAT COUNTRY USA
--	--	---	---

13a. FATHER'S NAME Jack M. Smedley	13b. MOTHER'S MAIDEN NAME Lucinda Lynch	14. NAME OF HUSBAND OR WIFE Betty Smedley
--	---	---

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 Address Mrs. Helen Anderson, 2212 S. 12th, St. Joseph, Mo
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Prostate & bone Metastasis		INTERVAL BETWEEN ONSET AND DEATH 10 mo.
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) Chronic Pyelonephritis	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N <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 **21 Jan 60** to **6 Feb 60** and last saw her alive on **May 60**
Death occurred at **3:25 p.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) H. Martin MD	22b. ADDRESS 706 Francis St. Joseph Mo	22c. DATE SIGNED 7 June 60
--	--	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6/8/1960	23c. NAME OF CEMETERY OR CREMATORY Agency Cemetery	23d. LOCATION (City, town, or county) Agency Mo.
--	------------------------------	--	--

24. FUNERAL DIRECTOR Heaton-Bowman	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. June 8, 1960	26. REGISTRAR'S SIGNATURE Wm. Clark Woodell
--	-----------------------------------	---	---

BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION N. Martin, M.D.

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th, St

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.