

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS MAY 17 1960

60-020596

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 188 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Township</u>		c. CITY OR TOWN <u>Kennett</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 4</u>		d. STREET ADDRESS (If outside, give location) <u>104 West Fifth St.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>OLLIE</u> Middle <u>LEE</u> Last <u>SMITH</u>	4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1960</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>April 25, 1896</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>17</u>	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 _____	11. BIRTHPLACE (City and state or country) <u>Green County, Ark.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Henry Brashers</u>	13b. MOTHER'S MAIDEN NAME <u>Mattie Rowe</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, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Records State Hospital No. 4, Farmington, 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>Staphylococcus Septicemia - - - - -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Abt. 1 wk.</u>
DUE TO (b) <u>Cellulitis of the lower back - - - - -</u>		<u>2 wks.</u>
DUE TO (c) _____		

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Psychosis with syphilitic meningo-encephalitis (General Paresis).</u>		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
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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 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 _____
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21. I attended the deceased from Jan. 8, 1960 to May 12, 1960 and last saw her/him alive on May 12, 1960
Death occurred at 4:10 A. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John C. Brenner M.D.</u>	22b. ADDRESS <u>State Hospital No. 4, Farmington, Missouri</u>	22c. DATE SIGNED <u>5-12-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 14, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakridge Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kennett, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Miller Funeral Home, Farmington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 14, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</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 Paul K. Dugal

Licensed Embalmer No. 4120

P. O. Address Farmington

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.