

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-022619**  
STATE FILE NUMBER

FILED VS. JUN 16 1960 41

Registration District No. \_\_\_\_\_ Primary Registration District No. 5288 Registrar's No. 58

INDEXED

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Clay</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Washington Township</u> |  | Length of stay in 1b<br><u>4 years</u>   | c. CITY OR TOWN <u>Lawson</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION                  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>1/2 mi east of Lawson</u><br>Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

|  |                                  |   |   |  |   |  |
|--|----------------------------------|---|---|--|---|--|
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>JOANN</u> Middle <u>CLARK</u> Last <u>SMITH</u>                       |                                  |   | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>17</u> Year <u>1960</u> |  |   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 2 '73</u>                              | 9. AGE (last birthday)<br><u>87</u>                  | 10. UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>          |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><u>Knoxville Mo</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>            |  |
| 13a. FATHER'S NAME<br><u>Harmon J. Clark</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Elizabeth Thomas</u>  |   | 14. NAME OF HUSBAND OR WIFE<br><u>Kelly W. Smith</u> |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>489-44-1574</u>   | 17. INFORMANT<br><u>Mrs Cleo Goodman Lawson Mo</u><br>Address       |  |   |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10'</u>   |
| IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>   |  |  |
| DUE TO (b) <u>Arteriosclerosis</u>  |  |  |
| DUE TO (c)  |  |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

|  |   |  |  |
|--|---|--|--|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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 type="checkbox"/>   | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION<br><u>Lawson</u> | COUNTY<br><u>Ray</u> | STATE<br><u>Mo</u> |
| 21. I attended the deceased from <u>4-14-58</u> to <u>17 May '60</u> and last saw her <u>alive</u> on <u>5-9-60</u><br>Death occurred at <u>7:45 am</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |                      |                    |

|  |                                 |  |   |
|--|---------------------------------|--|---|
| 22a. SIGNATURE (Degree or title)<br><u>George E Sanders M.D.</u> |                                 | 22b. ADDRESS<br><u>Excelsior Springs, Mo.</u>                | 22c. DATE SIGNED<br><u>5-19-60</u>                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>       | 23b. DATE<br><u>May 19 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lawson Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Lawson Mo</u> |
| 24. FUNERAL DIRECTOR<br><u>Jarman Funeral Home</u>               | ADDRESS<br><u>Lawson Mo</u>     | 25. DATE REC'D. BY LOCAL REG.<br><u>6-3-60</u>               | 26. REGISTRAR'S SIGNATURE<br><u>Barlene Hutchings</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Linda J. Jansman

Licensed Embalmer No. 458

P. O. Address Excelsior Springs

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