

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS - JUL 1-8 1960

-60-026206
 STATE FILE NUMBER

Registration District No. 65 Primary Registration District No. _____ Registrar's No. 37

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

3. NAME OF DECEASED (Type or print) First <u>MURPHY</u> Middle <u>SMITH</u> Last			4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u>	IF UNDER 24 HR Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>SUNNER MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Daniel Smith</u>		13b. MOTHER'S MAIDEN NAME <u>LIEUCHA WHEELWAGER</u>		14. NAME OF HUSBAND OR WIFE <u>OSA Smith</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>500-28-3924</u>		17. INFORMANT <u>WM Smith</u> Address <u>Brunswick MO</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>1 YRS</u>
IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CORONARY THROMBOSIS</u>	
	DUE TO (c) <u>CORONARY SCLEROSIS</u>	<u>10 YRS</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>HYPERTENSION</u>		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 checked="" 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 <u>5:15</u> a.m. / p.m. / Month / Day / Year			
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

21. I attended the deceased from JUNE 1944 to JULY 14 1960 and last saw him alive on JULY 13 1960
 Death occurred at 5:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Kenneth L Peroneanu D.O.</u>		22b. ADDRESS <u>TRIPPLETT, MO</u>		22c. DATE SIGNED <u>JULY 15 '60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>haleside</u>	23d. LOCATION (City, town, or county) (State) <u>SUNNER MO</u>	

24. FUNERAL DIRECTOR <u>S. L. HEIPARD Mendon MO</u>		25. DATE RECD. BY LOCAL REG. <u>July 15-1960</u>	26. REGISTRAR'S SIGNATURE <u>Dovie Smith</u>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Kenneth L. Rosenkrance.

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 *K. L. Rosenkrance*

Licensed Embalmer No. 3970

P. O. Address Mendon

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.