

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012894  
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 5164 Registrar's No. 103

FILED MAY 9 1961

1. PLACE OF DEATH a. COUNTY <u>Calloway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton Twp.</u>	Length of stay in 1b <u>4 Month</u>	c. CITY OR TOWN <u>Laddonia</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 <u>5 Mi. South East Mo.</u>		d. STREET ADDRESS (If outside, give location) <u>2 Mi. South of Laddonia, Mo.</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Harrison Smith</u>	4. DATE OF DEATH Month Day Year <u>5 - 2 - 1961</u>
---	---

5. SEX <u>Male</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>2-21-1884</u>	9. AGE (last birthday) <u>77</u>	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) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Audrain County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
--	---	--	--

13a. FATHER'S NAME <u>James Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Bybee</u>	14. NAME OF HUSBAND OR WIFE <u>Virgie Mapes 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>	17. INFORMANT <u>Bert E. Smith</u> Address <u>428 Dröstt Road St. Charles, Mo.</u>
---	---

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>Myocardial Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial degeneration</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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? 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 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 <u>2-4-61</u> to <u>Death</u> and last saw her alive on <u>3-28-61</u> Death occurred at <u>12 noon</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>John J. Brown MD</u>	22b. ADDRESS <u>Fulton Mo</u>	22c. DATE SIGNED <u>5-3-61</u>
---	----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-5-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laddonia Cemetery</u>	23d. LOCATION (City, town, or county) <u>Laddonia, Mo.</u>
--	------------------------------	--	---

24. FUNERAL DIRECTOR <u>Wilkey &amp; Bienhoff</u>	ADDRESS <u>Laddonia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 3-1961</u>	26. REGISTRAR'S SIGNATURE <u>Maritta Lawrence</u>
--	---------------------------------	---	--

DATE AMENDED

INSTEAD OF DOCUMENT

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Clyde C. Hickey

Licensed Embalmer No. 3820

P. O. Address Perry, Ind

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.