

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030329

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 109

AMENDED

FILED AUG 29 1961

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>LOUISIANA</u>	Length of stay in 1b <u>38 YRS</u>	c. CITY OR TOWN <u>LOUISIANA</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) <u>HOSPITAL OF NEBRASKA ST.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>111 NEBRASKA ST</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <u>BERTHA ANN SMITH</u>	4. DATE OF DEATH Month <u>AUG</u> Day <u>22</u> Year <u>1961</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>12-2-1879</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or when retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>PIKE Co MO</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>WILLIAM INGRAM</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH M. WILLIAMS</u>	14. NAME OF HUSBAND OR WIFE <u>CHAS. D. 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 <u>CHARLES SMITH</u>	Address <u>LOUISIANA 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>Toxic Myocarditis</u> <u>Pyelonephritis</u> DUE TO (b) <u>Arteriosclerosis</u> <u>Severe Hypertrophy Arthritis</u> also <u>Gall Bladder Disease, Peptic Ulcer.</u> DUE TO (c) <u>Secondary Anemia</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 to 3 wks</u> <u>5 yrs</u> <u>5 yrs</u> <u>2 yrs</u> <u>6 mths</u>
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 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 1955 to 8/22/61 and last saw her alive on 8/22/61
Death occurred at 9:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Chas. H. Lueder</u> (Degree or title)	22b. ADDRESS <u>M.D. 122 S. 3rd Street</u> <u>Louisiana, Missouri</u>	22c. DATE SIGNED <u>8/23/61</u>
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23a. BURIAL, CREMATION, OR OTHER (Specify)	23b. DATE <u>AUG 24 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVER VIEW</u>	23d. LOCATION (City, town, or county) (State) <u>LOUISIANA MO</u>
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24. FUNERAL DIRECTOR <u>COLLIER FUNERAL SERVICE</u> ADDRESS <u>LOUISIANA MO</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 26-61</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Geo. M. Collier

Licensed Embalmer No. 3839

P. O. Address Louisiana

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.