

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 262 STATE FILE NUMBER -61-032294

FILED SEP 18 1961

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|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cole</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cole</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u> | | Length of stay in 1b <u>10 days</u> | | c. CITY OR TOWN <u>Jefferson City</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>St. Marys Hosp.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>South 10 Mi. Drive Route # 5</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Belle</u> Last <u>Smith</u> | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1961</u> | | | | | | | | | |
| 5. SEX <u>Female</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>8/31/1896</u> | | 9. AGE (last birthday) <u>65</u> | | IF UNDER 1 YEAR Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HR Hours <u></u> Min. <u></u> | |
| 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 <u>Home</u> | | | 11. BIRTHPLACE (City and state or country) <u>Bucklin Missouri</u> | | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | | | |
| 13a. FATHER'S NAME <u>W. W. Roselle</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Sallie Edwards</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>N. H. 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>UNKNOWN</u> | | 17. INFORMANT <u>N. H. Smith</u> Address <u>Jefferson City, 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>Renal artery thrombosis with</u> DUE TO (b) <u>Hypertensive and arteriosclerotic</u> DUE TO (c) <u>cardiovascular disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>4 yrs.</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 checked="" 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 <u></u> a.m. <u></u> p.m. <u></u> | | Month, Day, Year <u></u> | | | | | | | | | | | |
| 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>June 8, 1961</u> to <u>9-8-61</u> and last saw her/him alive on <u>Sept 8, 1961</u> Death occurred at <u>11:45</u> <u>6</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>L. B. Kleber M.D.</u> | | | | | | 22b. ADDRESS <u>Jefferson City, Mo</u> | | | 22c. DATE SIGNED <u>9-15-61</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>9-10-61</u> | | 23c. NAME OF CEMETERY OR CREMATOR <u>Rothville Cemetery</u> | | | 23d. LOCATION (City, town, or county) <u>Rothville Missouri</u> | | | | | | |
| 24. FUNERAL DIRECTOR <u>Gideon Houser, Jefferson City, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>15 September 1961</u> | | 26. REGISTRAR'S SIGNATURE <u>R.P. Harris M.D. - Richter Dep</u> | | | | | | | |

DATE AMENDED
INSTEAD OF
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

SEP 19 1961
OCT 6 1961

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 Bill McLaughlin, Student Embalmer No. 620

working under my personal supervision.

Student Bill McLaughlin Signed Gideon N. Houser
Signature of Student Embalmer

Licensed Embalmer No. 45-79

P. O. Address Jefferson City

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.