MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-003323
STATE FILE NUMBER

AMENDED

Registration District No. 314 Primary Registration District No. 6057 Registrar's No. 5

FILED FEB 5 1962

1. PLACE OF DEATH
a. COUNTY St Clair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Center
Length of stay in 1b: 9 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY St Clair
c. CITY OR TOWN Lowry City
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) RFD #1
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Creed Middle M. Last Smith
4. DATE OF DEATH: Month Jan Day 20 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-20-92
9. AGE (last birthday): 69
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Cedar, Co Mo
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Andrew Smith
13b. MOTHER'S MAIDEN NAME: Sarah Strange
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Violet Smith Address: Lowry City Mo

MEDICAL CERTIFICATION

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
IMMEDIATE CAUSE (a)	Ruptured myocardium	seconds
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Myocardial Infarction	14 da
DUE TO (c)	Coronary thrombosis	14 da

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: ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1 Sept 61 to 20 Jan 62 and last saw ~~him~~ alive on 17 Jan 62
Death occurred at 10:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: D H Shesler (Degree or title) MD
22b. ADDRESS: Osceola Mo
22c. DATE SIGNED: 25 Jan 62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1-24-62
23c. NAME OF CEMETERY OR CREMATORY: Kidds Chapel
23d. LOCATION (City, town, or county) (State): Lowry City Mo

24. FUNERAL DIRECTOR: Goodrich Funeral Home ADDRESS: Osceola
25. DATE RECD. BY LOCAL REG.: 1-26-62
26. REGISTRAR'S SIGNATURE: Ruth Sievers

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

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_____ Signed F B Goodrich

Signature of Student Embalmer

Licensed Embalmer No. 3038

P. O. Address Osceola Mo

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.