

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022161

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 864

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED JUL 2 1962</b>	
<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <b>Butler</b></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b> Length of stay in 1b <b>8 Mos.</b></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1032 Henry St</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>Missouri</b> COUNTY <b>Butler</b></p> <p>c. CITY OR TOWN <b>Poplar Bluff</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <b>1032 Henry</b> Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>3. NAME OF DECEASED</b> First <b>LILLIE SMITH</b> Middle Last</p>	
<p><b>4. DATE OF DEATH</b> Month <b>6-15-62</b> Day Year</p>	
<p><b>5. SEX</b> <b>Female</b></p>	<p><b>6. COLOR OR RACE</b> <b>White</b></p>
<p><b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>3-31-1882</b></p>
<p><b>9. AGE (last birthday)</b> <b>80</b></p>	<p><b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HR</b> Hours Min.</p>
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>	<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b></p>
<p><b>11. BIRTHPLACE</b> (City and state or country) <b>Missouri</b></p>	<p><b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b></p>
<p><b>13a. FATHER'S NAME</b> <b>Manuel Niswonger</b></p>	<p><b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b></p>
<p><b>14. NAME OF HUSBAND OR WIFE</b> <b>Joe M. Smith</b></p>	
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b></p>	<p><b>16. SOCIAL SECURITY NO.</b> <b>None</b></p>
<p><b>17. INFORMANT</b> <b>Joe M. Smith Poplar Bluff, Mo.</b></p>	<p>Address</p>
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia 12 hrs</b></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic cardiac decompens 2 wks</b></p> <p>DUE TO (c) <b>Arteriosclerotic myocarditis 10 yrs</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Emphysema</b></p> <p>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</p>	
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p>
<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p><b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year</p>	
<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p><b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE</p>	
<p><b>21. I attended the deceased from</b> <b>6/13/62</b> to <b>6/15/62</b> and last saw her/him alive on <b>6/15/62</b></p> <p>Death occurred at <b>10:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p><b>22a. SIGNATURE</b> (Degree or title) <b>Cornil A. Post M.D.</b></p>	<p><b>22b. ADDRESS</b> <b>Poplar Bluff, Mo.</b></p>
<p><b>22c. DATE SIGNED</b> <b>6/27/62</b></p>	
<p><b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>	<p><b>23b. DATE</b> <b>6-18-62</b></p>
<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lawrence Mem. Park</b></p>	<p><b>23d. LOCATION</b> (City, town, or county) (State) <b>Walnut Ridge, Ark.</b></p>
<p><b>24. FUNERAL DIRECTOR</b> <b>Higginbotham's Walnut Ridge, Ark.</b></p>	<p><b>25. DATE RECD. BY LOCAL REG.</b> <b>6/27/1962</b></p>
<p><b>26. REGISTRAR'S SIGNATURE</b> <b>Thelma Graham</b></p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 Robert C. Higgins

Licensed Embalmer No. 772 Arkansas

P. O. Address Walnut Ridge, Ark.

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.