

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-030394

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 91 Primary Registration District No. 3012 Registrar's No. 85

FILED SEP 6 1962

VS 300  
Rev. 4/59

6001

22009

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DATE AMENDED

1/16/63

1/16/63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

Fat embolism of artery (pulmonary vessels - tuberculosis

Pulmonary tuberculosis in addition to brain syndrome

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Attendant

ITEM NO. SHOULD READ

18 II

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Clay</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Independent city</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>2150 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>No permanent address</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <b>MELVIN</b> Middle <b>WILLIAM</b> Last <b>SMITH</b>			Month <b>August</b> Day <b>10</b> Year <b>1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-25-91</b>
9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR	IF UNDER 24 HR
		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail Handler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Iberia, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>James Paulin Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Ellen Maxwell</b>	14. NAME OF HUSBAND OR WIFE <b>- - - -</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Irley Dale Phillips, cousin Granite City, Illinois</b>
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) <b>Tuberculosis, pulmonary, far advanced, active</b>			<b>3 years</b>
DUE TO (b) <b>Fat embolism of artery (pulmonary vessels)</b>			
DUE TO (c) <b>- - - - -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic brain syndrome of unknown cause advanced, active</b>			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 Month, Day, Year a.m. p.m.			
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. Attended the deceased from <b>Sept. 20, 1956</b> to <b>Aug. 10, 1962</b>			
Death occurred at <b>4:10</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>JOSEF ADRIANY, M.D., Acting Pathologist</b>		22b. ADDRESS <b>VA Consolidated Center Ex. Spgs Div., Wadsworth, Kansas</b>	22c. DATE SIGNED <b>8-14-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-14-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wadsworth</b>	23d. LOCATION (City, town, or county) (State) <b>Wadsworth, Kansas</b>
24. FUNERAL DIRECTOR <b>Prichard Funeral Home, Inc. Excelsior Springs, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>8-27-62</b>	26. REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>

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 Ernest Jassman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, 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.